ORIGINAL
-Application
Dyersburg Regional Medical Ctr.

CN1403-007

STATE OF TENNESSEE
Health Services and Dev Agency
Office 31607001
3/14/2014 11:01 AM

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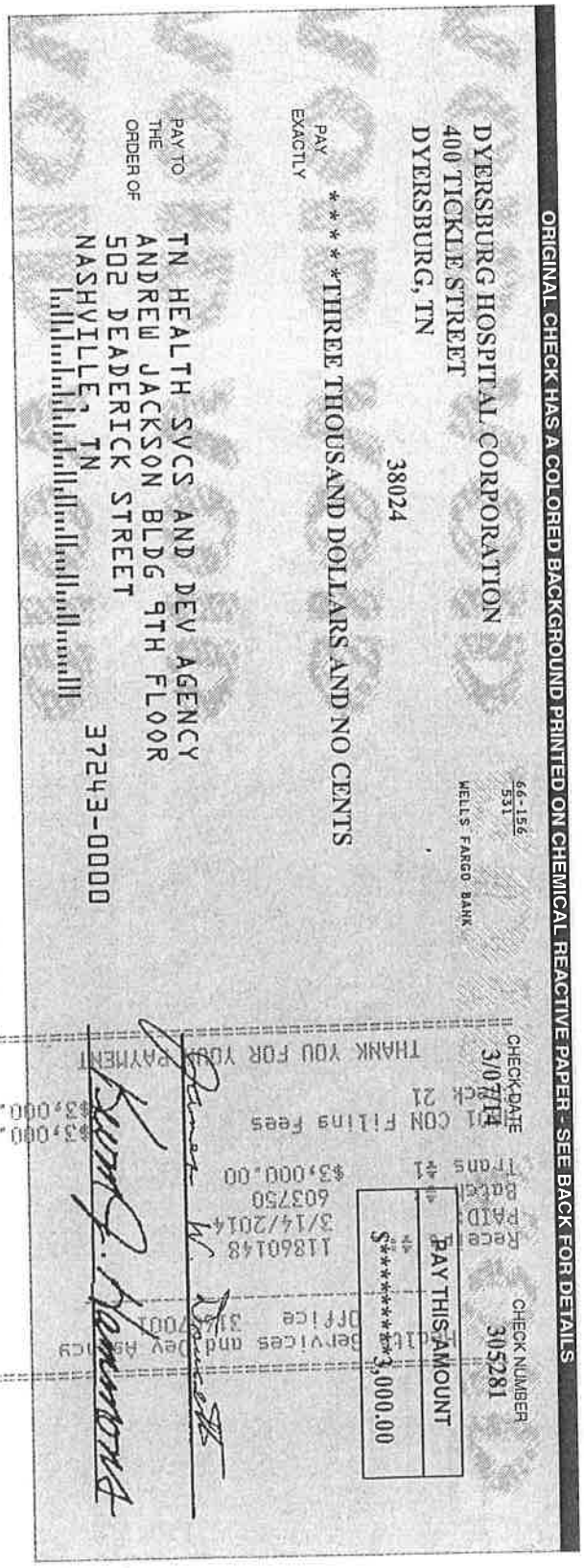
CN1403-007



CERTIFICATE OF NEED APPLICATION

FOR

DYERSBURG REGIONAL MEDICAL CENTER

Expansion Of Existing Cardiac Catheterization Service to Include Interventional Cardiac Catheterization Procedures

Dyer County, Tennessee

March 14, 2014

Contact Person:

Jerry W. Taylor, Esq.
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, Tennessee 37219
615-782-2228

SECTION A:

APPLICANT PROFILE

1. **Name of Facility, Agency, or Institution**

Dyersburg Regional Medical Center
Name

400 Tickle Street — Dyer
Street or Route — **County**

Dyersburg — TN — 38024
City — **State** — **Zip Code**

2. ***Contact Person Available for Responses to Questions***

Jerry W. Taylor — Attorney
Name — **Title**

Stites & Harbison, PLLC — jerry.taylor@stites.com
Company Name — **Email address**

401 Commerce Street, Suite 800 — Nashville — TN — 37219
Street or Route — **City** — **State** — **Zip Code**

Attorney — 615-782-2228 — 615-742-0703
Association with Owner — **Phone Number** — **Fax Number**

3. ***Owner of the Facility, Agency or Institution***

Dyersburg Hospital Corporation — 615-465-7000
Name — **Phone Number**

c/o Community Health Systems Professional Services Corp., 4000 Meridian Blvd. — Williamson
Street or Route — **County**

Franklin — TN — 37067
City — **State** — **Zip Code**

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship		F.	Government (State of TN or Political Subdivision)
B.	Partnership		G.	Joint Venture
C.	Limited Partnership		H.	Limited Liability Company
D.	Corporation (For Profit)	X	I.	Other (Specify)_____
E.	Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS. Organizational documentation is attached as Attachment A, 4 Organizational Documentation.

5. ***Name of Management/Operating Entity (If Applicable)***

N/A

Name

Street or Route **County**

City **State** **Zip Code**

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D. Option to Lease
B.	Option to Purchase		E. Other (Specify) _____
C.	Lease of _____ Years		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

A copy of the deed for the hospital property is attached as Attachment A, 6, Deed.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify)	X	I. Nursing Home
B.	GeneralAmbulatory Surgical Treatment Center (ASTC),		J. Outpatient Diagnostic Center
C.	Multi-Specialty		K. Recuperation Center
D.	ASTC, Single Specialty		L. Rehabilitation Facility
E.	Home Health Agency		M. Residential Hospice
F.	Hospice		N. Non-Residential Methadone Facility
G.	Mental Health Hospital Mental Health Residential		O. Birthing Center
H.	Treatment Facility Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify)_____
			Q. Other (Specify) _____

8. Purpose of Review *(Check) as appropriate--more than one response may apply)*

A.	New Institution		
B.	Replacement/Existing Facility		
C.	Modification/Existing Facility		
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) Expansion of Diagnostic Cardiac Cath to include Invasive Cardiac Cath (PCI)	X	
E.	Discontinuance of OB Services		
F.	Acquisition of Equipment		
G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*		
H.	Change of Location		
I.	Other (Specify)_____ _____		

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9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds		*Staffed*	*Beds*	*TOTAL Beds at*
		Licensed	**CON*	*Beds*	*Proposed*	*Completion*
A.	Medical	147		60		
B.	Surgical	20		15		
C.	Long-Term Care Hospital					
D.	Obstetrical	18		18		
E.	ICU/CCU	10		10		
F.	Neonatal	10		10		
G.	Pediatric	10		4		
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds	10		0		
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	**225**	**0**	**117**	**0**	**225**

10. **Medicare Provider Number:** 44-0072

Certification Type: Hospital

11. **Medicaid Provider Number:** 44-0072

Certification Type: Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

DRMC is an existing licensed hospital certified for both Medicare and Medicaid

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.**

United Healthcare Community Plan

BlueCare

TennCare Select

Will this project involve the treatment of TennCare participants?

Yes

If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

DRMC has contracts with all three TennCare MCOs in the West Tennessee region.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

N/A

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. **Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

RESPONSE: Dyersburg Regional Medical Center ("DRMC") is a 225-bed community hospital located in Dyersburg, Tennessee. DRMC is a member of Community Health Systems, Inc. ("CHS"), which is headquartered in Franklin, Tennessee. CHS owns, operates or leases 206 hospitals in 29 states as of February 2014. As a member of CHS, DRMC is in a position to benefit from the experience gained by health system hospitals, which will be particularly useful in regards to the applicant's proposal to expand its service capabilities with this application.

DRMC serves the needs of over 190,000 people residing in a in a 7-County area in west Tennessee and Missouri. The Counties in DRMC's service area include Crocket, Dyer, Gibson, Lake, Lauderdale, and Obion Counties in Tennessee, and Pemiscot County in Missouri. Currently, DRMC is one of only two hospitals located within this 7-County area that have a cardiac catheterization lab, with neither hospital having therapeutic cardiac catheterization ("PCI") or open heart surgery capabilities. When evaluating the demographics of the DRMC service area, it is clear that the applicant is providing healthcare services to a patient population that has significantly higher rates of mortality from heart disease and acute myocardial infarctions ("AMI," "STEMI," or heart attack), higher rates of poverty, and a higher percentage of elderly when compared to the state and the nation. In addition, all of the Counties in DRMC's service area are designated as medically underserved areas ("MUAs") by the Health Resources and Services Administration ("HRSA"). MUAs are characterized by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population[1]. These factors contribute to a population with a heightened need for improvements to access to care that will aid in improving the health status of the community.

Patients that require treatment options beyond the scope of services offered by DRMC -- PCI or open heart surgery -- are transferred or referred to a provider based in a County outside of the

[1] "Find Shortage Areas: MUA/P by State and County," Health Resources and Services Administration, http://muafind.hrsa.gov/index.aspx, Accessed 23 January 2014.

service area. This situation causes delays to treatment, adds unnecessary costs to patient care with increased EMS transports over longer distances, and places residents in the DRMC service area in a situation that involves unnecessary risks. According to data from the National Registry of Myocardial Infarction ("NRMI"), patients who are transferred for primary PCI are treated 71 minutes later than patients who receive primary PCI locally. Additionally, the NRMI registry demonstrates that a door-to-balloon time of 2.5 to 3 hours, as seen in patients transferred for PCI, is associated with a 60% increase in risk-adjusted mortality compared with a door-to-balloon time of less than 2 hours[2]. With the approval to initiate PCI services at DRMC, patients that reside in the service area would now be able to travel to a hospital offering PCI services in less than 1 hour, with the majority of residents able to travel to DRMC in less than 30 minutes.

Due to the initiation of a diagnostic cardiac catheterization service at DRMC in 2009, the applicant would require a relatively minimal investment to advance its capabilities to offer PCI. DRMC will not need to renovate its physical plant to offer the service, and therefore has no renovation or construction costs associated with this project. The total capital investment to introduce PCI services at DRMC is $200,000. Given the relatively low cost of entry, the initiation of a PCI services would be financially viable decision for the applicant. Additionally, PCI services will allow DRMC to better utilize existing space and equipment that is already in place for the diagnostic catheterization program. At the same time, the inability to advance DRMC's capabilities to offer PCI services has the potential to cause erosion to the volume of diagnostic catheterization currently performed.

Through an evaluation of patient transfer data, it is clear that DRMC has a high volume of patients with cardiovascular disease presenting to the hospital. In fact, in 2013 alone DRMC transferred over 1,000 patients for cardiovascular reasons. With non-invasive testing and diagnostic catheterization capabilities on-site, clearly a number of patients presenting to DRMC are considered high risk or are in need of a higher level of cardiac care that is not offered at the hospital today. The market potential for an expansion in capabilities to offer PCI services indicates DRMC will meet the established volume thresholds for a PCI program within its first full year of operation. With no PCI program in the DRMC service area, DRMC, with the approval to offer PCI, will have no effect on provider volumes for those that are located in the seven counties it serves. Additionally, given the significantly high mortality rates for heart disease and AMI in the region, a new PCI program will improve access to necessary care while having a marginal effect on programs located outside of the DRMC market.

In summary, the proposed project will improve access to the recognized standard of care in the treatment of AMI, is economically feasible, provides a necessary service to Tennesseans, and reduces unnecessary risks to the patient population DRMC serves. For these reasons and more, the applicant requests that the Tennessee Health Services and Development Agency approve its application to expand its capabilities to offer therapeutic cardiac catheterization services to the communities it serves.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

[2] Reference: Wharton, Thomas P., "The Case for Community Hospital Angioplasty," Circulation. 2005; 112: 3509-3534.

A. **Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.**

If the project involves none of the above, describe the development of the proposal.

RESPONSE: Not applicable (NA). The applicant, DRMC, will not require construction or renovation to initiate therapeutic cardiac catheterization ("Percutaneous Coronary Intervention," or "PCI," or "coronary angioplasty") services, inclusive of primary and elective angioplasty. DRMC currently performs diagnostic cardiac catheterization services. PCI services will be performed in the existing cardiac catheterization laboratory.

B. **Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.**

RESPONSE: Not applicable (NA). The expansion in services does not require any change in the number and type of beds.

C. **As the applicant, describe your need to provide the following health care services (if applicable to this application):**

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Treatment**
15. **Neonatal Intensive Care Unit**

16. **Non-Residential Methadone Treatment Centers**
17. **Open Heart Surgery**
18. **Positron Emission Tomography**
19. **Radiation Therapy/Linear Accelerator**
20. **Rehabilitation Services**
21. **Swing Beds**

RESPONSE: Since 2009, DRMC has offered diagnostic cardiac catheterization services. DRMC is proposing to offer therapeutic cardiac catheterization services, also known as percutaneous coronary intervention ("PCI") and angioplasty, including both primary and elective cases. Due to the applicant's inability to provide a higher level of care, patients that are considered high-risk, patients who have a history of coronary artery disease and those that present to the emergency department with an acute myocardial infarction ("heart attack," or "AMI"), and those that require an intervention as determined through diagnostic catheterizations are referred and/or transferred to facilities that offer higher levels of cardiac care not currently provided at DRMC. This situation places patients in an undesirable and risky position for many reasons, including increasing the risk for infection or injury to the surgical access site due to transport or receiving multiple incisions, increasing the time it takes to be treated, and increasing the cost of care. Ultimately, transferring patients is not considered the "standard of care", which in the simplest terms would entail providing therapeutic catheterization services to these patients that are otherwise transferred or bypass DRMC today.

It is in the best interests of patients experiencing a life-threatening event such as a heart attack to receive the appropriate treatment safely in the timeliest manner available. Indeed, the phrase "time is heart muscle" is used to describe the permanent irreversible damage to their myocardium ("heart muscle") that occurs from the onset of an AMI until treatment is delivered.

Upon approval of this CON, DRMC would have the capability to save lives and improve patient outcomes by improving access to the standard of care for patients experiencing a heart attack. Currently, the closest PCI center to DRMC is approximately 48 miles away. Given the current traffic patterns and route characteristics, it takes approximately 50 minutes or more for patients to travel from DRMC to a hospital with PCI capabilities. This unnecessary travel time undoubtedly impacts patient outcomes. The ability to initiate treatment for AMI patients at the time they present to DRMC with symptoms will afford the best possible outcome.

The current national benchmark measure for timeliness of care for patients suffering from an AMI, as established by the American College of Cardiology, is "door-to-balloon" time. Currently, the accepted benchmark for door-to-balloon time, or time to reperfusion from patient presentation at the hospital, is 90 minutes or less. Nationally, all hospitals that provide primary PCI, PCI to STEMI patients, demonstrate an average door-to-balloon time of 64.5 minutes. Whereas, the average door-to-balloon time for patients requiring a transfer for care is 121 minutes.[3] Nearly doubling the time to treatment from patient presentation

[3] Dehmer, G.J. et al. "A Contemporary View of Diagnostic Cardiac Catheterization and Percutaneous Coronary Intervention in the United States." JACC, 2012; 60 (20): 2017-2013.

with symptoms is simply not acceptable when the standard of care can be offered safely at DRMC. Every additional minute of not receiving timely treatment escalates the risk of patient death.

Primary angioplasty has been proven to be the treatment of choice for AMI patients, and is supported by numerous clinical trials conducted in the United States and Europe, as described below:

> "In the total DANAMI-2 population and in transferred patients, the absolute 6% reduction of the composite endpoint achieved with primary angioplasty at 30 days was maintained and still highly significant after 3 years. This finding is in accordance with long-term results from the PRAGUE-2 trial. A sustained benefit of primary angioplasty during long-term follow-up was also reported from the smaller but pioneering Zwolle and PAMI trials, in which all patients, however, were admitted directly to angioplasty centers."[4]

In addition to the benefits derived from initiating primary PCI services (PCI for AMI or STEMI patients) at DRMC, there is also a distinct clinical benefit to offering elective, or scheduled, PCI services to the population the hospital serves. Currently, when significant coronary artery disease is identified in patients receiving a diagnostic cardiac catheterization at DRMC, the patients are referred to a provider outside of the area for additional treatment options. This referral pattern causes discontinuity in patient care, creates unnecessary travel/access hardships for the patients and their families, and increases the costs of care to the patients. With approval of this application, DRMC would be in position to provide treatment options at the time of diagnosis of disease. Thus, the patient's primary care physician and Cardiologist could follow their patients care path from admission to the hospital, through the hospital stay, and post-discharge. Additionally, patients would now be in a position to receive their care closer to home. The ability for a provider to offer elective PCI capabilities is logical when primary PCI services are initiated. In offering elective procedures, DRMC would not simply be caring for the patients with more complex needs that present to the hospital emergently, but also those that are stabilized and scheduling their procedures.

The inability to provide PCI services necessitates transfers out of the organization and will result in **a delay in providing the current standard of care, increase unnecessary risks to DRMC patients, as well as have the potential to erode DRMC's diagnostic catheterization volumes thus impacting the program's long-term viability.**

In November 2011, the ACCF/AHA/SCAI published guidelines for PCI, which change the recommendations of care appropriateness from a Class III (of no benefit or potentially harmful) to a IIb (the benefit is greater than or equal to the risk) indication. By elevating the clinical indication, the new guidelines offered further evidence from the Cardiology professional community for increasing the number of facilities that should be able to perform PCI. These societies have based their latest guidelines on the success and preliminary outcomes from the national CPORT-E trial, and have considered other national

[4]The Danish multicentre randomized study of fibrinolytic therapy vs. primary angioplasty in acute myocardial infarction (the DANAMI-2 trial): outcome after 3 years follow-up - European Heart Journal (2008) 29, 1259–1266

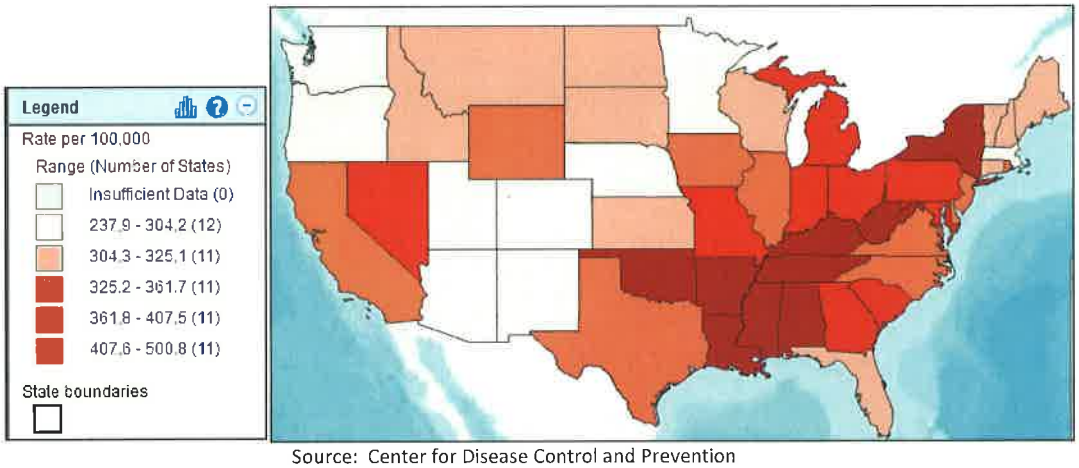
studies such as the MAYO Clinic meta-analysis[5]. The ability of an organization to reduce wait times for this necessary treatment option will reduce unnecessary patient risks.

Many patients over the age of 65 rely on family members and/or public transportation to access medical care, and increasing distance and travel time only adds greater burden. Caring for patients needs within their community alleviates the travel burden, while providing easier access-to-care, continuity-of-care, thus preventing a fragmented approach that can negatively impact outcomes. More specifically, the prevalence and risk for developing cardiovascular disease increases over the age 45, and the need for cardiovascular services is most prevalent in the over 65 age cohort. DRMC cares for an aging population in its service area, which heightens the need as a provider to ensure ease of access to care as well as continuity of care.

The impact of heart disease upon patient mortality in the state of Tennessee is concerning. In the most recent data available from the Centers for Disease Control and Prevention ("CDC"), mortality rates for heart disease are among the highest in the country. From 2008-2010, Tennessee was reported as having the *ninth highest* heart disease mortality rate when compared to other states in the country. Additionally, Tennessee had the *sixth highest* AMI mortality rate in the nation[6].

Figure 1 below depicts the heart disease mortality rates by state in the country. It is alarming that Tennessee is in the top ten worst states as it relates to these mortality rates, and it may be indicative of a situation where access to care is an issue.

Figure 1 – Heart Disease Death Rate per 100,000, 35+, All Race, All Gender 2008-2010, USA



Source: Center for Disease Control and Prevention

When examining the statistics further, it is clear that Tennesseans have a mortality rate from heart disease that is 18.9% higher than the country. Table 1 below provides a breakdown of the heart disease mortality rates by race and ethnicity in Tennessee and the country.

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[5] Singh, Mandeep, et al. "Percutaneous Coronary Intervention at Centers With and Without On-site Surgery: A Meta-analysis." JAMA, vol 306; No.22, December 14, 2011, pages 2487-2494

[6] Data Source: *Interactive Atlas of Heart Disease and Stroke*, a website developed by the Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention. http://www.cdc.gov/dhdsp/maps

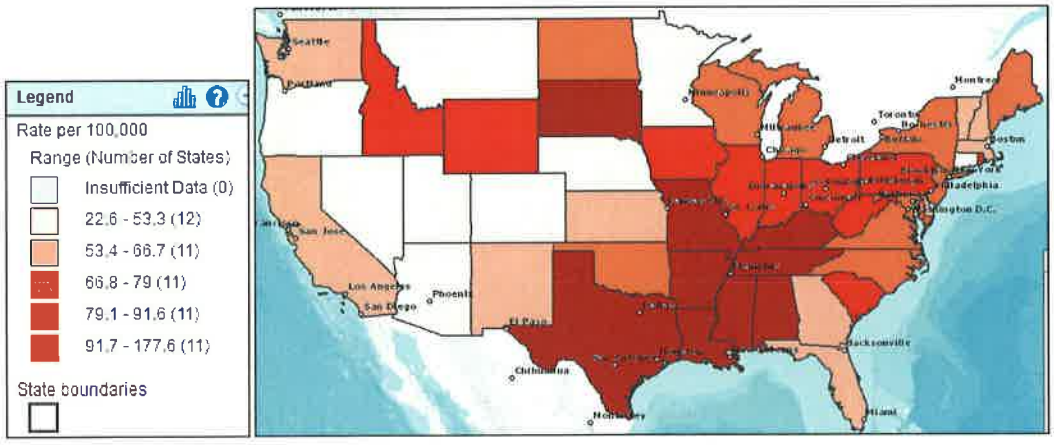
Table 1 – Heart Disease Death Rate per 100,000, 35+, All Race, All Gender, 2008-2010

Race or Ethnicity	Heart Disease Death Rate per 100,000	
	Tennessee State	United States
All Races	426.5	358.6
Black (non-Hispanic)	509.6	461.3
White (non-Hispanic)	420.8	360.3
Hispanic	120.3	266.8
American Indian and Alaskan Native	151.3	315.9
Asian and Pacific Islander	252.6	204.8

Source: Center for Disease Control and Prevention

As mentioned earlier, therepeutic catheterization procedures are considered the standard of care for patients experiencing an AMI. With the sixth highest mortality rate for AMI in the country from 2008-2010, it is likely that patients in Tennessee are not accessing or able to access care in a timely fashion. Figure 2 below depicts the mortality rate for AMI by state in the United States.

Figure 2 – Acute Myocardial Infarction (AMI) Death Rate per 100,000, 35+, All Race, All Gender 2008-2010, USA



Source: Center for Disease Control and Prevention

When examining the Tennessee mortality rate for AMI as compared to the country, it is clear that Tennesseans have experienced a mortality rate that is over 58% higher than that of the rest of the country. This is cause for significant concern, and is indicative of a need to improve patient access to treatment options for AMI. A comparison of the state rates to the country can be found in Table 2 below.

Table 2 – Acute Myocardial Infarction Death Rate per 100,000, 35+, All Race, All Gender, 2008-2010

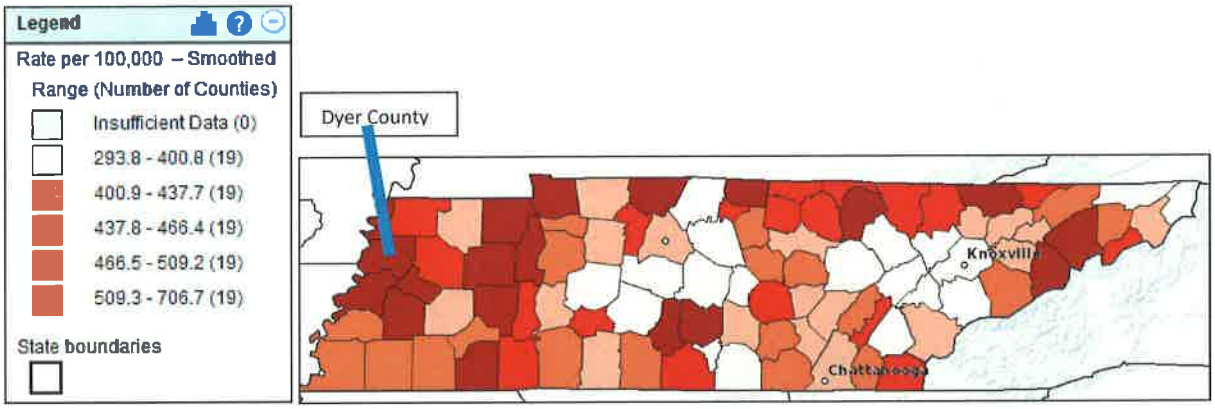
Race or Ethnicity	Acute Myocardial Infarction Death Rate per 100,000	
	Tennessee State	National
All Races	119.9	75.7
Black (non-Hispanic)	126.7	89.2
White (non-Hispanic)	121.2	77.3
Hispanic	28	59.1

American Indian and Alaskan Native	-1	683
Asian and Pacific Islander	82.9	448

Source: Center for Disease Control and Prevention

Of significant concern in DRMC's situation is the fact that the majority of Counties with relatively high heart disease mortality rates are located in west Tennessee. In fact, Dyer County has one of the highest heart disease death rates in the state. Figure 3 below illustrates the heart disease mortality rates by County within the State of Tennessee.

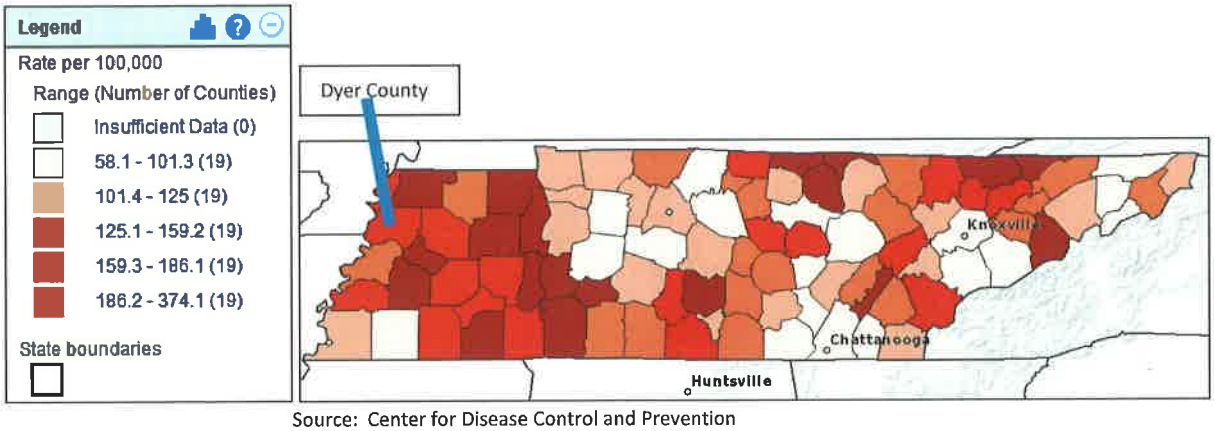
Figure 3 – Heart Disease Death Rate per 100,000, 35+, All Race, All Gender 2008-2010, Tennessee



Source: Center for Disease Control and Prevention

Correspondingly, the majority of counties in Tennessee with the highest AMI mortality rates are also located in west Tennessee. As is the case with heart disease, Dyer County also has a relatively high mortality rate for AMI. Figure 4 below illustrates AMI mortality rates by County in the State of Tennessee from 2008-2010.

Figure 4 – Acute Myocardial Infarction (AMI) Death Rate per 100,000, 35+, All Race, All Gender 2008-2010, Tennessee



Source: Center for Disease Control and Prevention

With approval of this application, it is DRMC's intent to positively impact cardiovascular patient care in the area through improved access to the recognized standard of care for AMI patients, thus positively impacting patient outcomes and mortality rates for this patient population in west Tennessee.

D. Describe the need to change location or replace an existing facility.

RESPONSE: Not applicable (NA). DRMC does not need to change location or replace an existing facility.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

a. Describe the new equipment, including:

1. Total cost; (As defined by Agency Rule).
2. Expected useful life;
3. List of clinical applications to be provided; and
4. Documentation of FDA approval.

b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable (NA). DRMC does not require the acquisition of fixed major medical equipment that exceeds the cost of $1.5 million. The applicant plans to invest a total of $200,000 into equipment, including an imaging console that enhances the diagnosis of atherosclerosis (hardening of the arteries) and heart disease using intravascular ultrasound (IVUS) imaging and fractional flow reserve (FFR) software , and an uninterrupted power supply (UPS) in the cardiac catheterization lab to ensure no power supply is interrupted by a power failure.

2. For mobile major medical equipment:

a. List all sites that will be served;
b. Provide current and/or proposed schedule of operations;
c. Provide the lease or contract cost.
d. Provide the fair market value of the equipment; and
e. List the owner for the equipment.

RESPONSE: Not applicable (NA). This proposal does not require the acquisition of mobile major medical equipment that exceeds the cost of $1.5 million.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable (NA). This proposal does not require the acquisition of major medical equipment that exceeds the cost of $1.5 million.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. Size of site (in acres);

2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: A plot plan for DRMC is attached as Attachment B (III) (A) DRMC Plot Plan

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: DRMC is located within 3 miles of US Highway 51, US Highway 412, and Interstate 155. All of these highways are considered major traffic thoroughfares within the DRMC service area. For this reason, DRMC is readily accessible by car and ambulance. DRMC is not on a public transportation route.

IV. **Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.**
NOTE: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see Attachment B (IV) DRMC Cardiac Cath Lab Floor Plan for floor plan drawing of the existing cardiac catheterization laboratory.

V. **For a Home Health Agency or Hospice, identify:**

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

RESPONSE: Not applicable (NA). DRMC is not proposing the introduction or expansion of a Home Health Agency or Hospice.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**
   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

Standards and Criteria Regarding Certificate of Need Applications for All Cardiac Catheterization Services

Applicants proposing to provide any type of cardiac catheterization services must meet the following minimum standards:

1. **Compliance with Standards: The Division of Health Planning is working with stakeholders to develop a framework for greater accountability to these Standards and Criteria. Applicants should indicate whether they intend to collaborate with the Division and other stakeholders on this matter.**

RESPONSE: DRMC will remain compliant and accountable to the fore mentioned standards and criteria. DRMC intends to collaborate with the division and the other stakeholders.

2. **Facility Accreditation: If the applicant is not required by law to be licensed by the Department of Health, the applicant should provide documentation that the facility is fully accredited or will pursue accreditation by the Joint Commission or another appropriate accrediting authority recognized by the Centers for Medicare and Medicaid Services (CMS).**

RESPONSE: DRMC is fully accredited by the Joint Commission, and is licensed and in good standing with the Department of Health.

3. **Emergency Transfer Plan: Applicants for cardiac catheterization services located in a facility without open heart surgery capability should provide a formalized written protocol for immediate and efficient transfer of patients to a nearby open heart surgical facility (within 60 minutes) that is reviewed/tested on a regular (quarterly) basis.**

RESPONSE: DRMC possesses a formalized agreement for the immediate and efficient transfer of patients who, in the unlikely event, would require a rapid transport to a facility with on-site open heart

surgery. DRMC will remain in compliance with the 60 minutes transfer time as well review and test this transfer process on a quarterly basis. DRMC included a copy of the transfer agreement in Attachment C Specific Cardiac Cath Criteria (3) DRMC Transfer Agreements.

4. **Quality Control and Monitoring: Applicants should document a plan to monitor the quality of its cardiac catheterization program, including, but not limited to, program outcomes and efficiency. In addition, the applicant should agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation 2.**

RESPONSE: DRMC will maintain compliance respective to program quality control and monitoring. DRMC will be participating and submitting to the American College of Cardiology's National Cardiovascular Data Registry CathPCI registry to monitor its quality and outcomes relative to peer hospitals across the country. DRMC will agree and cooperate with all efforts related to quality enhancements as sponsored by the State of Tennessee.

5. **Data Requirements: Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.**

RESPONSE: DRMC agrees to provide the Department of Health with all requested information and statistical data relevant to the operation and provisions of PCI services. DRMC will report that data within the format and time requested.

6. **Clinical and Physical Environment Guidelines: Applicants should agree to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). As of the adoption of these Standards and Criteria, the latest version (2001) may be found online at:**
http://www.acc.org/qual ityand science/cl in ical/consensus/angiography/dirIndex.ht m.
Where providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and the steps the provider is taking to ensure quality. These guidelines include, but are not limited to, physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.

RESPONSE: DRMC will maintain compliance with and documentation of those requirements as outlined by the most current guidelines as published by the American College of Cardiology, and the Society for Cardiac Angiography and Interventions. Additionally, DRMC will maintain compliance with all guidelines related to physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with the supporting emergency services.

7. Staffing Recruitment and Retention: The applicant should generally describe how it intends to maintain an adequate staff to operate the proposed service, including, but not limited to, any plans to partner with an existing provider for training and staff sharing.

RESPONSE: DRMC plans to utilize its relationship to other CHS hospitals to access training for the existing staff at the hospital caring for cardiac catheterization lab patients. This training will ensure that the DRMC staff is prepared to care for the specific needs of PCI patients. In addition, DRMC plans to recruit additional, experienced personnel to complement the existing staff that is already in place. The experienced personnel will be employed prior to the start of the PCI program to ensure all appropriate and experienced staff is in place to care for a new patient type at the hospital.

8. Definition of Need for New Services: A need likely exists for new or additional cardiac catheterization services in a proposed service area if the average current utilization for all existing and approved providers is equal to or greater than 70% of capacity (i.e., 70% of 2000 cases) for the proposed service area.

RESPONSE: This application is not intended to increase the capacity of cardiac catheterization labs in the DRMC service area. Rather, this application is intended to allow DRMC to advance its service offerings within its existing cardiac catheterization lab. Through approval of the application, DRMC will be in a position to better utilize the capacity that exists within the current cardiac catheterization lab. Additionally, none of the hospitals within DRMC's seven-County service area currently have PCI capabilities. Therefore, the initiation of PCI services at DRMC will have no effect on volumes of existing providers within the service area.

9. Proposed Service Areas with No Existing Service: In proposed service areas where no existing cardiac catheterization service exists, the applicant must show the data and methodology used to estimate the need and demand for the service. Projected need and demand will be measured for applicants proposing to provide services to residents of those areas as follows:

Need. The projected need for a service will be demonstrated through need-based epidemiological evidence of the incidence and prevalence of conditions for which diagnostic and/or therapeutic catheterization is appropriate within the proposed service area.

Demand. The projected demand for the service shall be determined by the following formula:

A. Multiply the age group-specific historical state utilization rate by the number of residents in each age category for each county included in the proposed service area to produce the projected demand for each age category;

B. Add each age group's projected demand to determine the total projected demand for cardiac catheterization procedures for the entire proposed service area.

RESPONSE: Determining the need for an expansion to include PCI capabilities at DRMC included evaluating the service area demographics, understanding the incidence and mortality rates from heart disease and AMI, and determining the current availability and ease of access to these services.

DRMC's service area population is projected to grow by 1% over the next 5 years. This growth is supported by significant growth in the 65 and older age cohort. Based on resident population projections developed by the Tennessee State Data Center, DRMC's service area population ages 19 and over (adult population) is expected to reach more than 143,000 by 2018, an increase of 2%. The population in the 65 and older age cohort in DRMC's service area is growing considerably and accounts for a substantial portion of the total population. In fact, DRMC's service area population in this age cohort is expected to grow by approximately 12 percent over the next five years. People aged 65 and over are at greater risk for cardiovascular disease compared to the younger population, and thus the

demand for advanced cardiac services is greater in this age cohort. This elderly population is typically averse to travel long distances for care, which may be due to their increased need to engage family member assistance to make the trip. Traveling outside of their community for cardiac care that can be provided safely closer to home is a hardship this population should not have to endure. Clearly, adding PCI services at DRMC will alleviate this travel hardship for patients and their families.

The population in DRMC's proposed service area is not only older, but in a lower income bracket, on average when compared to the majority of Tennessee citizens, as evidenced by a high unemployment rate, a relatively low median income, and a relatively high percentage of Medicaid patients seeking care at DRMC. In 2013, DRMC's hospital payor mix included 22% of patients covered by Medicaid. Additionally, residents in the service area suffer from some of the highest heart disease and heart attack mortality rates in the country. These determinants of health significantly impact access to care, as service area residents are challenged by high rates of heart disease, in a largely elderly population, that has a relatively low income when compared to other regions in Tennessee.

DRMC's service area includes some of the poorest counties in Tennessee and Missouri. Out of the ninety-five Counties in Tennessee, Lake County ranks first in percent of people living in poverty at 43.7%, and Lauderdale County ranks fourth at 30.7%. Additionally, Pemiscot County in Missouri ranks second in Missouri counties with 30% of residents living in poverty. *All* counties in DRMC's proposed service area have higher percentages of the population living in poverty than the state of TN, the state of MO, and the U.S. Congruently, all counties in the service area have a lower median income than TN, MO, and the U.S., and all DRMC service area counties have populations with lower percentages with high school graduates than the state and U.S.

The median household income for residents of Lake County is only $23,441, which is the second lowest median income for counties in Tennessee. Likewise, Pemiscot County has the second lowest median household income for counties in Missouri at only $26,647 annually. All counties in the proposed service area are lower than the $42,943 Tennessee annual median household income. The low income, coupled with high unemployment rates places residents in challenging situations, particularly when they are being told to travel roughly an hour away from home to receive advanced cardiac services that can safely be offered close to home.

With almost 43,000 deaths, heart disease is the leading cause of death in Tennessee[7]. The population living in the proposed service area experiences prevalence and mortality of heart disease that is substantially higher than the State of Tennessee and national averages. In fact, the counties in DRMC's proposed service area rank in the highest quartile of heart disease mortality in the state of Tennessee, and *all* of the service area counties have higher heart disease mortality rates than Tennessee and the United States. In DRMC's proposed service area, Crockett County ranks first in Heart Disease Mortality out of all 95 Tennessee Counties with a mortality rate of 395.8 per 100,000 people[8]. Pemiscot County, Missouri has the second highest mortality rate in DRMC's proposed service area with a rate of 326.9 per 100,000 people. The remaining DRMC service area counties have heart disease mortality rates above 250 per 100,000 people, which are higher than the state of Tennessee, Missouri, and the United States mortality rates. Furthermore, the hospitalization rate of residents in all counties but one is higher than the state of Tennessee. Table 3 below depicts the heart disease death rates, rankings, and hospitalization in the proposed service area, Tennessee, Missouri, and the United States, and Table 4

[7] Data Source: TN DH Statistics 2007-2009

[8] Data Source: TN DH Office of Policy, Planning & Assessment Surveillance, Epidemiology, and Evaluation, Dec 2011

depicts AMI mortality rates and rankings in the proposed service area, Tennessee, Missouri, and the United States.

Table 3 – Heart Disease Mortality Rates, Rankings, and Hospitalization, Dyersburg Regional Medical Center Proposed Service Area, Tennessee (2011), Missouri, USA 2008-2010[9]

		Heart Disease					
Area	**County**	**Mortality - All Ages**	**Mortality Ranking (*1 = highest*) in State (TN) - All Ages** Total Counties TN=94, MO=115	**Mortality - Ages 35+**	**Mortality Ranking (*1 = highest*) in State - Ages 35+** Total Counties TN=94, MO=115	**Mortality Ranking (*1 = highest*) in USA - Ages 35+**	**Hospitalization**
Proposed Service Area	Crockett, TN	395.8	1	706.7	1	13	1,631.1
	Dyer, TN	250.4	35	550.3	9	155	2,146.2
	Gibson, TN	245.3	38	503.9	24	318	1,572.3
	Lake, TN	262.8	25	534.1	15	207	2,762.6
	Lauderdale, TN	279.4	15	537.8	13	144	1,827.8
	Obion, TN	253.6	33	509.2	20	291	1,305.3
	Pemiscot, MO	326.9	N/A	618.6	6	42	N/A
State & U.S	State of TN	220.7	N/A	426.5	N/A	9	1,306.8
	State of MO	209.1	N/A	405.4	N/A	13	N/A
	United States	190.6	N/A	358.6	N/A	N/A	N/A

Table 4 – AMI Mortality Rates& Rankings, Dyersburg Regional Medical Center Proposed Service Area, Tennessee (2011), Missouri, USA 2008-2010[10]

		AMI (Acute Myocardial Infarction) – Heart Attack		
Area	**County**	**Mortality - Ages 35+**	**Mortality Ranking (*1 = highest*) in State - Ages 35+** Total Counties TN=94, MO=115	**Mortality Ranking (*1 = highest*) in USA - Ages 35+**
Proposed Service Area	Crockett, TN	201.0	17	151
	Dyer, TN	160.8	36	444
	Gibson, TN	164.1	30	405
	Lake, TN	162.5	33	848
	Lauderdale, TN	156.8	43	480
	Obion, TN	249.7	10	70

[9] Data Sources: for Mortality All Ages and Hospitalization: Chronic Health Profile Regions and Counties: Tennessee, TN Department of Health Office of Policy, Planning & Assessment Surveillance, Epidemiology and Evaluation; for Mortality Ages 35+: National Vital Statistics System from National Center for Health Statistics via CDC

[10] Data Source: National Vital Statistics System from National Center for Health Statistics via CDC

	Pemiscot, MO	365.3	114	14
State & U.S	State of TN	119.9	N/A	6
	State of MO	120.0	N/A	5
	United States	75.7	N/A	N/A

With some of the highest heart disease and AMI mortality rates in the country, residents in DRMC's proposed service area are in great need for access to advanced cardiovascular care. Since "time is muscle," and delayed treatment equates to greater risk for permanent irreversible damage to heart muscle, it is paramount that DRMC's proposed service area population have access to treatment as quickly as possible. The excerpt below from "The Case for Community Hospital Angioplasty" illustrates this fact in more detail:

> "The mortality benefit of primary PCI decreases as the time delay to PCI increases, and this benefit may disappear when the delay to PCI is more than 1 hour compared with the time to administration of a fibrinolytic agent. Patients in the United States who are transferred for primary PCI are treated 71 minutes later than patients who receive primary PCI locally (171 versus 100 minutes), according to data from the NRMI [National Registry of Myocardial Infarction]. This same NRMI registry demonstrates that a door-to-balloon time of 2.5 to 3 hours, as seen in patients transferred for PCI, is associated with a 60% increase in risk-adjusted mortality compared with <2 hours from door to balloon time."[11]

If DRMC were to add PCI services, all residents living in DRMC's proposed service area would have access to PCI services in less than a 1 hour drive, and most would be able to get to DRMC in less than 20-30 minutes.[12] Table 5 below depicts the distance between DRMC and the two closest providers with PCI capabilities.

Table 5 – Distance and Travel time from Dyersburg Regional Medical Center to Nearest PCI Centers & Cardiac Services Available[13]

Hospital Name	Address	Miles from Dyersburg Regional Medical Center	Driving Time from Dyersburg Regional Medical Center	Major Roads	Cardiac Services Available		
					Open Heart Surgery	Diagnostic Cath	Therapeutic Cath
Dyersburg Regional Medical Center	*400 East Tickle Street, Dyersburg, TN 38024*	*N/A*	*N/A*	*N/A*	*No*	*Yes*	*No*
Regional Hospital of Jackson	367 Hospital Boulevard Jackson, TN 38305	47.8 miles	51 minutes	US-412 E	No	Yes	Yes

[11] Reference: Wharton, Thomas P., "The Case for Community Hospital Angioplasty," Circulation. 2005; 112: 3509-3534.
[12] Data Source: Google Maps
[13] Data Source: Google Maps, 2012 Tennessee Joint Annual Report

Jackson-Madison County General Hospital	620 Skyline Drive Jackson, TN 38301	48.4 miles	55 minutes	TN-20 E	Yes	Yes	Yes

Emergency Medical Service (EMS) providers are able to shorten access times using ambulances and, in some cases, air transport. However, the cost of EMS transport to patients is significant and adds to the overall cost of care for patients. It cannot be understated that across the country many EMS providers have taken a more active role in the facilitation of triaging and critically managing chest pain patients. Their direct involvement in the care and management of this patient population has become a driving force as many states are recognizing and addressing the need for these providers to transport these patients to the closest STEMI center.

From this information, DRMC believes the need for a service expansion exists within its service area. When evaluating the demand for PCI procedures at DRMC, the hospital attempted to proceed using the demand methodology outlined in this question. Through several requests, it was clear that patient utilization statistics by age cohort was not available from the Tennessee Department of Health. In absence of this data, DRMC attempted to request patient origin data at a ZIP code and/or County level by procedure code by which to develop patient utilization statistics. Unfortunately, this data was also unavailable. In absence of this data, DRMC estimated the demand for PCI procedures using an approach that was focused on patient transfer data that is tracked by DRMC and area EMS providers. The methodology when using these data sets is listed in the following section.

To project patient volumes for an expansion to offer PCI at DRMC, the applicant analyzed patient transfer data from the hospital records and that of EMS ground and air transfer providers in Dyersburg, Tennessee. The ground transport EMS provider, Dyersburg Regional Emergency Medical Services, services patients in the Dyer County market, whereas the air transport provider is based in Dyersburg, Tennessee and services a 60-mile radius surrounding their location.

Through an evaluation of this transfer data, it is clear that over 1,000 patients left DRMC for cardiovascular care in 2013, with an average of over 900 such transfers per year for the past 3 years. The primary reason that patients would be transferred from DRMC to other facilities for cardiac care is the lack of current capabilities at the hospital. As it relates to cardiac services, PCI and open heart surgery capabilities represent the significant gaps in the current services offered. The volume of ground and air transfers from DRMC for cardiac reasons for the previous three years can be found in Table 6 below.

Table 6 – Volume of Ground and Air Transfers for Cardiac Reasons from DRMC

Mode of Transfer	2011	2012	2013*
EMS Ground Transfer	777	935	1,018
EMS Air Transfer	(not available)	2	3
Total Transfers	**777****	**937**	**1,021**

*EMS Ground Transfer data was annualized for 2 months, and EMS Air Transfer data for 3 months for 2013.
**Total volume of transfers in 2011 is not reflective of EMS Air Transfer volume as it was not available.

In addition to the volume of transfers from DRMC, there are also patients that EMS providers transfer from the area without first stopping at DRMC. This may be due to the patient's history, condition,

and/or preference. If an EMS provider suspects a patient is having a heart attack, the provider will bypass DRMC and bring the patient to the nearest hospital that offers PCI services. Upon approval to expand services at DRMC to offer PCI, EMS providers would not need to drive by DRMC if it were the nearest hospital as it would then be able to provide the recognized standard of care to patients experiencing an AMI. Table 7 below displays the volume of patients transported from Dyer County to providers outside of the DRMC service area for cardiac care.

Table 7 – Volume of Patients Transported via EMS from Dyer County for Cardiac Reasons without Receiving Care at DRMC

Mode of Transport	2011	2012	2013*
EMS Ground Transport	102	132	170
EMS Air Transport	(not available)	47	44
Total Transports	**102****	**179**	**214**

*EMS Ground Transfer data was annualized for 2 months, and EMS Air Transfer data for 3 months for 2013.
**Total volume of transports in 2011 is not reflective of EMS Air Transfer volume as it was not available.

It is unclear what services were provided to each of the patients that were transferred in the data above. However, it is reasonable to assume that these patients were transferred to receive a higher level of cardiac care not available at DRMC (e.g., open heart surgery, coronary angioplasty), were deemed too high-risk for DRMC, and/or were managed medically at the receiving hospital. As a conservative approach to this transfer volume, DRMC assumed that just 25% of this patient population received a therapeutic catheterization procedure. Using this assumption, 309 patients transferred from DRMC or Dyer County via EMS providers would have had a PCI procedure performed in 2013. This total does not include the volume of patients that would have received an elective PCI procedure as an outpatient. As is the case with a number of other procedure types, patients receiving PCI procedures continue to migrate to an outpatient setting for their care. Although the rate of inpatient to outpatient PCIs can be 70%/30% respectively, DRMC projected a more conservative estimate of 80%/20% for these volume projections. If we assume that the 309 patients is representative of the 80% complement, then the total inpatient and outpatient PCI patients would total 386 for 2013. With roughly 95% of cardiac interventions occurring in the above 45 age cohort, it can be assumed that 367 of the 386 PCI patients were in this age cohort. It is important to note that this projection does not include patients that reside in other service area Counties that bypassed DRMC as well, due to the EMS transfer data not being available. For this and other reasons, 386 PCIs is deemed to be a conservative estimate of the market for PCI volumes in the DRMC service area.

When evaluating the validity of these volume projections, DRMC compared the utilization rate based on these calculations in the service area to that of the country. Table 8 below provides a comparison of utilization rates within the DRMC service area to the nation.

Table 8 – 2013 PCI Utilization Rates in DRMC Service Area and the Nation

2013 Service Area Population	190,186
2013 Estimated PCI Procedures in DRMC Service Area	386
Service Area Utilization Rate for PCI *(per 1,000 population)*	2.03
National Utilization Rate for PCI* *(per 1,000 population)*	**2.80**

*Represents a calculated utilization rate based upon 2011 discharge data derived from AHRQ HCUPNet; Population sourced from U.S. Census data for 2011.

As can be seen from Table 8 above, this approach to projecting PCI volumes is considered reasonable and conservative. Although DRMC anticipates positively impacting the relatively low utilization rates for PCI, the volume projection methodology for a new program at DRMC did not incorporate a growth in the calculated utilization rate. Rather, the rate of 2.03 PCI per 1,000 of the population was applied to the population projections for the area to determine the market potential for a PCI program at DRMC. Therefore, any growth in market potential is based directly on the projected changes in the service area population.

When projecting potential PCI patient volumes, DRMC's ability to attract patients for these services is expected to grow over time. Although the vast majority of patients transferred from the area are seeking care at DRMC first, the hospital assumes that it will need to develop a reputation for this new service. Therefore, DRMC assumed it would capture one-third of the projected market potential in its first year of operation, growing to one half of the potential by the third year of operation. Details of this volume projection methodology can be found in Table 9 below.

Table 9 – DRMC PCI Volume Projections

	2013		Year 1 (2015)	Year 2 (2016)	Year 3 (2017)
PCI Volume in DRMC Service Area	386		392	395	398
Projected DRMC Market Share	0%		33%	42%	50%
DRMC PCI Volume	0		131	165	199

When analyzing the market potential for PCI services in the service area, it is clear that the demand exists for this service at DRMC. Using this methodology, DRMC is projected to exceed the minimum volume thresholds of 400 diagnostic/therapeutic cardiac catheterizations with at least 75 being therapeutic within the 1st year of operation with the initiation of a PCI program. For this reason, DRMC meets the market demand requirements for an expansion in capabilities to offer PCI.

10. Access: In light of Rule 0720-4-.01 (1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

b. Who documents that the service area population experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases or other clinical conditions applicable

to cardiac catheterization services that is substantially higher than the State of Tennessee average;

c. Who is a "safety net hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or

d. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.

RESPONSE:

a. DRMC is proposing to offer diagnostic and therapeutic cardiac catheterization services in medically underserved areas ("MUAs") as designated by the Health Resources and Services Administration ("HRSA"). As of January 2014, *all* counties within DRMC's proposed service area – Crockett-TN, Dyer-TN, Lake-TN, Lauderdale-TN, Obion-TN, and Pemiscot-MO Counties – are designated MUAs, "which are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population."[14] This further emphasizes the need for advanced cardiovascular care services for residents in the areas surrounding DRMC.

b. As referenced in the preceding question, the service area population that DRMC serves has a high incidence/mortality from heart disease when compared to the state and the country.

c. DRMC is not designated as a "safety net hospital".

d. DRMC commits to fulfilling this commitment, and continuing to provide services to TennCare and Medicare patients.

Specific Standards and Criteria for the Provision of Therapeutic Cardiac Catheterization Services. Applicants proposing to provide therapeutic cardiac catheterization services must meet the following minimum standards:

14. Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 400 diagnostic and/or therapeutic cardiac catheterization cases per year by its third year of operation. At least 75 of these cases per year should include a therapeutic cardiac catheterization procedure. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. Only cases including diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

RESPONSE: DRMC anticipates meeting the established requirement of 400 diagnostic and/or therapeutic catheterizations cases per year in its first year of operation. Additionally, in its first year of operation, DRMC projects the volume of therapeutic catheterization procedures to total 131. These volume projections satisfy the minimum volume standards referenced above.

Table 10 below displays the applicant's volume statistics and subsequent impact on lab utilization for the past three years with the projected volumes and annual utilization for each of the first two years following the initiation of therapeutic catheterization services at DRMC.

[14] "Find Shortage Areas: MUA/P by State and County," Health Resources and Services Administration, http://muafind.hrsa.gov/index.aspx, Accessed 23 January 2014.

Table 10 – DRMC's Historic and Projected Cardiac Catheterization Volumes and Lab Utilization

Dyersburg Regional Medical Center Utilization Statistics	HISTORIC			PROJECTED	
Service	**2011**	**2012**	**2013**	**Year 1**	**Year 2**
Diagnostic Cardiac Cath	376	322	218*	393	494
Therapeutic Cardiac Cath	0	0	0	131	165
Total Adult Cardiac Cath Lab Cases	**376**	**322**	**218**	**524**	**658**
DRMC Cardiac Cath Labs	**1**	**1**	**1**	**1**	**1**
Volume of Weighted Cases Available (2,000 per lab)	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**
DRMC Weighted Cases	**376**	**322**	**218**	**655**	**824**
Lab Utilization	**18.8%**	**16.1%**	**10.9%**	**32.8%**	**41.2%**

* The decline in volume in 2012 and 2013 was due to the departure of a Cardiologist form the medical staff. From May 2012 through August 2013, DRMC had one full-time Cardiologist on active staff at the hospital. In August 2013, a second full-time Cardiologist joined the active staff at DRMC.

15. Open Heart Surgery Availability: Acute care facilities proposing to offer adult therapeutic cardiac catheterization services shall not be required to maintain an on-site open heart surgery program. Applicants without on-site open heart surgery should follow the most recent American College of Cardiology/American Heart Association/Society for Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines). As of the adoption of these Standards and Criteria, the latest version of this document (2007) may be found online at: *http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.107.185159*
Therapeutic procedures should not be performed in freestanding cardiac catheterization laboratories, whether fixed or mobile. Mobile units may, however, perform therapeutic procedures provided the mobile unit is located on a hospital campus and the hospital has on-site open heart surgery. In addition, hospitals approved to perform therapeutic cardiac catheterizations without on-site open heart surgery backup may temporarily perform these procedures in a mobile laboratory on the hospital's campus during construction impacting the fixed laboratories.

RESPONSE: DRMC will maintain a formal transfer agreement with an open heart tertiary center as referenced above in number 3 from the *"Standards and Criteria Regarding Certificate of Need Applications for All Cardiac Catheterization Services"* DRMC will maintain compliance with the most recent American College of Cardiology/American Heart Association/Society for Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention. (ACC/AHA/SCAI Guidelines). Additionally, DRMC plans to perform PCI procedures in its existing cardiac catheterization lab that is currently located within the hospital's facility.

16. Minimum Physician Requirements to Initiate a New Service: The initiation of a new therapeutic cardiac catheterization program should require at least two cardiologists with at least one cardiologist having performed an average of 75 therapeutic procedures over the most recent five year

period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.

RESPONSE: DRMC intends to maintain compliance regarding the minimum physician requirements of at least two (2) interventional cardiologists with at least one having performed an average of 75 therapeutic cardiac procedures over the most recent five year period. DRMC affirms the cardiologists that will be providing therapeutic cardiac service will be either board eligible or board certified in cardiology and other relevant cardiac subspecialties. Several interventional Cardiologists that meet these guidelines have expressed an interest in working at a new PCI program at DRMC, but without the approval to proceed it is deemed premature at this point to contract with these eligible physicians.

17. Staff and Service Availability: Ideally, therapeutic services should be available on an emergency basis 24 hours per day, 7 days per week through a staff call schedule (24/7 emergency coverage). In addition, all laboratory staff should be available within 30 minutes of the activation of the laboratory. If the applicant will not be able to immediately provide 24/7 emergency coverage, the applicant should present a plan for reaching 24/7 emergency coverage within three years of initiating the service or present a signed transfer agreement with another facility capable of treating transferred patients in a cardiac catheterization laboratory on a 24/7 basis within 90 minutes of the patient's arrival at the originating emergency department.

RESPONSE: DRMC intends to maintain compliance in assuring all staff being available and on-site within 30 minutes of activation to care for an acute myocardial infarction (AMI) patient. DRMC intends to provide 24/7 emergency coverage at the outset of the PCI program. In addition, DRMC will ensure the transfer agreement for PCI is in place with another facility capable of treating transferred patients in a cardiac catheterization lab with 24/7 coverage.

18. Expansion of Services to Include Therapeutic Cardiac Catheterization: An applicant proposing the establishment of therapeutic cardiac catheterization services, who is already an existing provider of diagnostic catheterization services, should demonstrate that its diagnostic cardiac catheterization unit has been utilized for an average minimum of 300 cases per year for the two most recent years as reflected in the data supplied to and/or verified by the Department of Health.

RESPONSE: DRMC will demonstrate the ability to maintain the minimum volume requirement as defined by the Department of Health. In 2012, DRMC did not meet this established volume threshold due to the departure of a Cardiologist from the medical staff. From May 2012 through August 2013, DRMC had one full-time Cardiologist on active staff at the hospital. In August 2013, a second full-time Cardiologist joined the active staff at DRMC. DRMC anticipates performing volumes at a level that exceeds the state's minimum threshold in 2014 with the additional Cardiology coverage.

Across the country, it is become increasingly difficult for providers, without therapeutic cardiac catheterization capabilities, to attract and retain invasive and/or interventional Cardiologists. This is part of the reason that a number of providers without these capabilities are experiencing an erosion of volumes. In an effort to ensure the continued viability of the cardiac catheterization lab and the cardiology program at DRMC, it is important that the hospital is allowed to expand its cardiac catheterization program to include therapeutic capabilities.

Five Principles for Achieving Better Health (Tennessee State Health Plan).

Through the approval of this application, DRMC will be in a better position to advance the aim of the "Five Principles for Achieving Better Health" that was developed by the Division of Health Planning in Tennessee. A description of how DRMC will address each of these five principles is included below:

1. **The purpose of the State Health Plan is to improve the health of Tennesseans.**

RESPONSE: Through approval of this application, DRMC would be able to better provide for the health care needs of Tennesseans. As described in the previous sections of this application, heart disease incidence and mortality rates are relatively high in the state of Tennessee, but alarmingly so in the area that DRMC serves. A number of factors may contribute to this situation, but one of which relates to patients' access to care. Of the seven Counties in the DRMC service area, six are located in Tennessee. Currently, patients need to travel outside of this six County area for a therapeutic cardiac catheterization procedures. With approval of this application, DRMC would be in a position to offer this level of care closer to home, thus improving access, eliminating or reducing the travel burden on area patients and their families, and significantly reducing the need and related costs for emergent air and ground transport.

2. **Every citizen should have reasonable access to care.**

RESPONSE: As previously mentioned, there are no providers in the seven-county area that DRMC serves with therapeutic cardiac catheterization capabilities. This procedure has been proven to be safely offered in hospitals without surgery on-site, which is reflected in the latest American College of Cardiology guidelines and in the state of Tennessee's changes in regulation. Without a provider with these capabilities in the service area, patients and their families are forced to endure travel outside of the area for this higher level of care. Upon approval of this application, patients in the area will have access to this life saving procedure closer to home.

3. **The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.**

RESPONSE: Through approval of this application, DRMC will be in a better position to care for the growing cardiovascular needs of its service area population. With significant growth in the 65 and older age cohort, the demand for cardiovascular services is expected to grow. Thus, contributing to a service area with a high incidence and high mortality rates associated with heart disease. An expansion in capabilities to include therapeutic cardiac catheterization at DRMC will dramatically reduce the number of necessary emergent ground and air transports, thus reducing the cost of care in the health care system.

4. **Every citizen should have the confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

RESPONSE: As a new therapeutic cardiac catheterization program, it will be very important that DRMC closely monitors the clinical quality of this new service. The applicant is prepared

for this undertaking, and is committed to also benchmarking itself with hospitals across the country clinical and quality outcomes through participation in the American College of Cardiology's National Cardiovascular Data Registry CathPCI registry. DRMC will agree and cooperate with all efforts related to quality enhancements as sponsored by the State of Tennessee. These efforts will ensure DRMC is providing consistent, high-quality care to its patient population.

5. **The state should support the development, recruitment and retention of a sufficient and quality health care workforce.**

RESPONSE: Through approval of this application, DRMC will be in a position to offer new career opportunities to physicians and staff required to support a therapeutic cardiac catheterization program at the hospital. Additionally, through an expansion to its current catheterization capabilities, DRMC will be in a better position to recruit and retain consistent Cardiology coverage.

[END OF RESPONSES TO STANDARDS AND CRITERIA IN TENNESSEE STATE HEALTH PLAN]

b) **Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)**

RESPONSE: Not Applicable (N/A). DRMC is not applying for a Change of Site approval.

2. **Describe the relationship of this project to the applicant facility's long-range development plans, if any.**

RESPONSE: The ability to provide therapeutic catheterization capabilities is essential to the mission of DRMC. The advancement to offer PCI would be a logical expansion of the cardiac services offered to patients by DRMC today. The inability to provide this necessary service has the potential to further erode the diagnostic catheterization volumes at DRMC, thus impacting the long-term viability of DRMC as a full-service hospital. Without approval to proceed, DRMC would be hampered in its ability to provide the standard of care to the communities it serves.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: The proposed service area includes Crockett, Dyer, Gibson, Lake, Lauderdale, and Obion counties in Tennessee and Pemiscot County in Missouri. DRMC is located in Dyer County, TN, which is situated roughly in the center of this service area. The area that defines the service area for cardiac services at DRMC is illustrated in the map in Attachment C (III) Proposed Service Area Map.

The proposed service area is defined as the area representing the location of existing and potential cardiac patients to DRMC. To determine this area, DRMC reviewed its historical discharge data, population density, and geography. Approximately 97% of DRMC's total patient volume resides in the proposed service area. Although DRMC cares for patients residing outside of this proposed

service area, this amount accounts for less than 3% of DRMC's total inpatient discharges in 2013. Therefore, DRMC is confident that the proposed service area is representative of its market for therapeutic cardiac catheterization patients in this proposal.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: DRMC's service area population is projected to grow by 1% over the next 5 years. This growth is supported by significant growth in the 65 and older age cohort. Based on resident population projections developed by the Tennessee State Data Center, DRMC's service area population ages 19 and over (adult population) is expected to reach more than 143,000 by 2018, an increase of 2%.

The population in the 65 and older age cohort in DRMC's service area is growing considerably and accounts for a substantial portion of the total population. As displayed in Table 11, DRMC's service area population in this age cohort is expected to grow by approximately 12 percent over the next five years, which will account for all of the growth of the adult population during that time period. In addition, this segment of the population are expected to account for more than 17% of DRMC's service area population in 2014. People aged 65 and over are at greater risk for cardiovascular disease compared to the younger population, and thus the demand for advanced cardiac services is greater in this age cohort. This elderly population is typically averse to travel long distances for care, which may be due to their increased need to engage family member assistance to make the trip. Traveling outside of their community for cardiac care that can be provided safely closer to home is a hardship this population should not have to endure. Adding PCI services at DRMC will alleviate this travel hardship for patients and their families.

Table 11 – Dyersburg Regional Medical Center Proposed Service Area Population 2013-2018[15]

Dyersburg Regional Medical Center Proposed Service Area Population							
Population	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**% Change 2013-2018**
Age <19	50,096	49,899	49,719	49,571	49,439	49,410	-1%
Age 19-44	58,321	58,374	58,302	58,014	57,895	57,911	-1%
Age 45-64	50,644	50,446	50,494	50,667	50,675	50,478	0%
Age 65+	31,124	31,965	32,658	33,379	34,107	34,772	12%
Total	**190,186**	**190,684**	**191,173**	**191,630**	**192,116**	**192,570**	**1%**
Population % of Total	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	
Age <19	26%	26%	26%	26%	26%	26%	
Age 19-64	31%	31%	30%	30%	30%	30%	
Age 45-64	27%	26%	26%	26%	26%	26%	
Age 65+	16%	17%	17%	17%	18%	18%	
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	

[15] Data Source: Tennessee State Data Center (August 2013) and U.S. Census Bureau

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: The population in DRMC's proposed service area is not only older, but in a lower income bracket, on average when compared to the majority of Tennessee citizens, as evidenced by a high unemployment rate, a relatively low median income, and a relatively high percentage of Medicaid patients seeking care at DRMC. In 2013, DRMC's payor mix included 22% of patients covered by Medicaid. Additionally, as previously referenced residents in the service area suffer from some of the highest heart disease and heart attack mortality rates in the country. These determinants of health significantly impact access to care, as service area residents are challenged by high rates of heart disease, in a largely elderly population, that has a relatively low income when compared to other regions in Tennessee. Table 12 below portrays service area County demographics as compared to the state and nation.

Table 12 – Demographics, Dyersburg Regional Medical Center Proposed Service Area 2011, Tennessee, Missouri, USA 2010[16]

		Population Living in Poverty, All Ages					
Area	County	Percentage	Rank in State (TN,MO)	Rank in USA	Unemployment Rate (%)	Median Income	High School Graduate (%)
Service Area	Crockett	20.0%	45	897	9.0%	$35,370	73.4%
	Dyer	19.4%	53	1006	7.0%	$36,121	72.9%
	Gibson	18.8%	60	1103	9.5%	$34,050	74.5%
	Lake	43.7%	1	6	12.2%	$23,441	61.4%
	Lauderdale	30.7%	4	124	12.1%	$31,667	67.4%
	Obion	18.3%	67	1215	6.7%	$37,581	76.2%
	Pemiscot, MO	30.1%	2	131	10.2%	$26,647	N/A
State & U.S	State of TN	17.9%	N/A	N/A	7.9%	$42,943	82.0%
	State of MO	16.2%	N/A	N/A	6.8%	$47,202	86.8%
	United States	15.9%	N/A	N/A	7.3%	$52,762	85.4%

DRMC's service area includes some of the poorest counties in Tennessee and Missouri. Out of the ninety-five Counties in Tennessee, Lake County ranks first in percent of people living in poverty at 43.7%, and Lauderdale County ranks fourth at 30.7%. Additionally, Pemiscot County in Missouri ranks second in Missouri counties with 30% of residents living in poverty. *All* counties in DRMC's proposed service area have higher percentages of the population living in poverty than the state of

[16] Data Sources: for Tennessee & Tennessee Counties: Chronic Health Profile Regions and Counties: Tennessee, TN Department of Health Office of Policy, Planning & Assessment Surveillance, Epidemiology and Evaluation (December 2011); for Pemiscot, MO, State of MO, and U.S. rates: U.S. Census Bureau via CDC, 2010

TN, the state of MO, and the U.S. Congruently, all counties in the service area have a lower median income than TN, MO, and the U.S., and all DRMC service area counties have populations with lower percentages with high school graduates than the state and U.S.

The median household income for residents of Lake County is only $23,441, which is the second lowest median income for counties in Tennessee. Likewise, Pemiscot County has the second lowest median household income for counties in Missouri at only $26,647 annually. All counties in the proposed service area are lower than the $42,943 Tennessee annual median household income. The low income, coupled with high unemployment rates places residents in challenging situations, particularly when they are being told to travel roughly an hour away from home to receive advanced cardiac services that can safely be offered close to home.

DRMC is proposing to offer diagnostic and therapeutic cardiac cath services in medically underserved areas (MUAs) as designated by the Health Resources and Services Administration (HRSA). As of January 2014, *all* counties within DRMC's proposed service area – Crockett-TN, Dyer-TN, Lake-TN, Lauderdale-TN, Obion-TN, and Pemiscot-MO Counties – are designated MUAs, "which are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population."[17] This further emphasizes the need for advanced cardiovascular care services for residents in the areas surrounding DRMC.

With almost 43,000 deaths, heart disease is the leading cause of death in Tennessee[18]. The population living in the proposed service area experiences prevalence and mortality of heart disease that is substantially higher than the State of Tennessee and national averages. In fact, the counties in DRMC's proposed service area rank in the highest quartile of heart disease mortality in the state of Tennessee, and *all* of the service area counties have higher heart disease mortality rates than Tennessee and the United States. In DRMC's proposed service area, Crockett County ranks first in Heart Disease Mortality out of all 95 Tennessee Counties with a mortality rate of 395.8 per 100,000 people[19]. Pemiscot County, Missouri has the second highest mortality rate in DRMC's proposed service area with a rate of 326.9 per 100,000 people. The remaining DRMC service area counties have heart disease mortality rates above 250 per 100,000 people, which are higher than the state of Tennessee, Missouri, and the United States mortality rates. Furthermore, the hospitalization rate of residents in all counties but one is higher than the state of Tennessee. Table 13 below depicts the heart disease death rates, rankings, and hospitalization in the proposed service area, Tennessee, Missouri, and the United States, and Table 14 depicts AMI mortality rates and rankings in the proposed service area, Tennessee, Missouri, and the United States.

[17] "Find Shortage Areas: MUA/P by State and County," Health Resources and Services Administration, http://muafind.hrsa.gov/index.aspx, Accessed 23 January 2014.
[18] Data Source: TN DH Statistics 2007-2009
[19] Data Source: TN DH Office of Policy, Planning & Assessment Surveillance, Epidemiology, and Evaluation, Dec 2011

Table 13 – Heart Disease Mortality Rates, Rankings, and Hospitalization, Dyersburg Regional Medical Center Proposed Service Area, Tennessee (2011), Missouri, USA 2008-2010[20]

		Heart Disease					
Area	County	Mortality - All Ages	Mortality Ranking (*1 = highest*) in State (TN) - All Ages Total Counties TN=94, MO=115	Mortality - Ages 35+	Mortality Ranking (*1 = highest*) in State - Ages 35+ Total Counties TN=94, MO=115	Mortality Ranking (*1 = highest*) in USA - Ages 35+	Hospitalization
Proposed Service Area	Crockett, TN	395.8	1	706.7	1	13	1,631.1
	Dyer, TN	250.4	35	550.3	9	155	2,146.2
	Gibson, TN	245.3	38	503.9	24	318	1,572.3
	Lake, TN	262.8	25	534.1	15	207	2,762.6
	Lauderdale, TN	279.4	15	537.8	13	144	1,827.8
	Obion, TN	253.6	33	509.2	20	291	1,305.3
	Pemiscot, MO	326.9	N/A	618.6	6	42	N/A
State & U.S	State of TN	220.7	N/A	426.5	N/A	9	1,306.8
	State of MO	209.1	N/A	405.4	N/A	13	N/A
	United States	190.6	N/A	358.6	N/A	N/A	N/A

Table 14 – AMI Mortality Rates& Rankings, Dyersburg Regional Medical Center Proposed Service Area, Tennessee (2011), Missouri, USA 2008-2010[21]

		AMI (Acute Myocardial Infarction) – Heart Attack		
Area	County	Mortality - Ages 35+	Mortality Ranking (*1 = highest*) in State - Ages 35+ Total Counties TN=94, MO=115	Mortality Ranking (*1 = highest*) in USA - Ages 35+
Proposed Service Area	Crockett, TN	201.0	17	151
	Dyer, TN	160.8	36	444
	Gibson, TN	164.1	30	405
	Lake, TN	162.5	33	848
	Lauderdale, TN	156.8	43	480
	Obion, TN	249.7	10	70
	Pemiscot, MO	365.3	114	14
State & U.S	State of TN	119.9	N/A	6
	State of MO	120.0	N/A	5

[20] Data Sources: for Mortality All Ages and Hospitalization: Chronic Health Profile Regions and Counties: Tennessee, TN Department of Health Office of Policy, Planning & Assessment Surveillance, Epidemiology and Evaluation; for Mortality Ages 35+: National Vital Statistics System from National Center for Health Statistics via CDC

[21] Data Source: National Vital Statistics System from National Center for Health Statistics via CDC

	United States	75.7	N/A	N/A

With some of the highest heart disease and AMI mortality rates in the country, residents in DRMC's proposed service area are in great need for access to advanced cardiovascular care. Since "time is muscle," and delayed treatment equates to greater risk for permanent irreversible damage to heart muscle, it is paramount that DRMC's proposed service area population have access to treatment as quickly as possible. The excerpt below from "The Case for Community Hospital Angioplasty" illustrates this fact in more detail:

> "The mortality benefit of primary PCI decreases as the time delay to PCI increases, and this benefit may disappear when the delay to PCI is more than 1 hour compared with the time to administration of a fibrinolytic agent. Patients in the United States who are transferred for primary PCI are treated 71 minutes later than patients who receive primary PCI locally (171 versus 100 minutes), according to data from the NRMI [National Registry of Myocardial Infarction]. This same NRMI registry demonstrates that a door-to-balloon time of 2.5 to 3 hours, as seen in patients transferred for PCI, is associated with a 60% increase in risk-adjusted mortality compared with <2 hours from door to balloon time."[22]

If DRMC were to add PCI services, all residents living in DRMC's proposed service area would have access to PCI services in less than a 1 hour drive, and most would be able to get to DRMC in less than 20-30 minutes.[23] Table 15 below depicts the distance between DRMC and the two closest providers with PCI capabilities.

Table 15 – Distance and Travel time from Dyersburg Regional Medical Center to Nearest PCI Centers & Cardiac Services Available[24]

Hospital Name	Address	Miles from Dyersburg Regional Medical Center	Driving Time from Dyersburg Regional Medical Center	Major Roads	Cardiac Services Available		
					Open Heart Surgery	Diagnostic Cath	Therapeutic Cath
Dyersburg Regional Medical Center	*400 East Tickle Street, Dyersburg, TN 38024*	*N/A*	*N/A*	*N/A*	*No*	*Yes*	*No*
Regional Hospital of Jackson	367 Hospital Boulevard Jackson, TN 38305	47.8 miles	51 minutes	US-412 E	No	Yes	Yes
Jackson-Madison County General Hospital	620 Skyline Drive Jackson, TN 38301	48.4 miles	55 minutes	TN-20 E	Yes	Yes	Yes

[22] Reference: Wharton, Thomas P., "The Case for Community Hospital Angioplasty," Circulation. 2005; 112: 3509-3534.

[23] Data Source: Google Maps

[24] Data Source: Google Maps, 2012 Tennessee Joint Annual Report

Emergency Medical Service (EMS) providers are able to shorten access times using ambulances and, in some cases, air transport. However, the cost of EMS transport to patients is significant and adds to the overall cost of care for patients, as shown in Table 16. It cannot be understated that across the country many EMS providers have taken a more active role in the facilitation of triaging and critically managing chest pain patients. Their direct involvement in the care and management of this patient population has become a driving force as many states are recognizing and addressing the need for these providers to transport these patients to the closest STEMI center.

Table 16 – EMS Ground and Air Transport Distance and Costs[25]

Hospital Name	Address	Ground Miles from Dyersburg Regional Medical Center	Ground Transfer Cost	Approximate Nautical Miles from Dyersburg Regional Medical Center	Air Transfer Cost
Regional Hospital of Jackson	367 Hospital Boulevard Jackson, TN 38305	47.8 miles	$1,657	38.8 miles	$30,513
Jackson-Madison County General Hospital	620 Skyline Drive Jackson, TN 38301	48.4 miles	$1,666	41.9 miles	$31,775

DRMC will remain focused on improving access to care for the poor, elderly, women, and racial and ethnic minorities. In DRMC's proposed service area, the elderly population (over age 65) is expected to increase by 12 percent in the next five years, indicating an increased need for cardiovascular-related services given that people aged 65 and over have higher risk of cardiovascular disease. Additionally, DRMC's proposed service area has a large percentage of families with female heads of household, as compared to the rest of Tennessee and Missouri. Women are clinically misdiagnosed for cardiovascular disease, particularly when they are experiencing a heart attack, and more attention should be paid to properly diagnosing women. Given the fact that heart disease remains the number one cause of death for women in the United States, DRMC intends to become actively involved in the pursuit of educating the community, and will specifically utilize the tools provided by the American Heart Association "Go Red For Women" campaign; thus increasing awareness through education and treatment options specific to the female population.

The applicant's plan to expand services by purchasing requisite equipment adequate to provide therapeutic catheterization services will serve the local community in Dyer County and the surrounding counties as the population becomes increasingly older and experiences more health problems. A local and easily accessible cardiac catheterization laboratory that not only provides critical diagnostic services but also has the capability to intervene when necessary will be a vital asset to the northwest Tennessee community.

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and**

[25] Data Sources: Source: Costs & Ground Miles provided by EMS Representative in Dyersburg, TN; for Nautical Miles: Daft Logic Version 5.7 (22/01/2014), http://www.daftlogic.com/

its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: There are currently no existing or certified PCI centers in DRMC's proposed service area. The nearest PCI centers, Regional Hospital of Jackson and Jackson-Madison County General, are located outside of the proposed service area in Madison County. DRMC did not discharge any patients originating from Madison County in 2013, which is why it is not considered part of hospital's service area. Utilization trends for hospitals located within the DRMC service are listed in Table 17 below.

Of the seven hospitals in DRMC's service area, none have PCI capabilities today. Therefore, it can be safely assumed that DRMC would not impact any of the other six hospitals in the service area with an expansion to offer PCI services.

Table 17 – Cardiac Utilization Trends 2010-2012, Dyersburg Regional Medical Center Proposed Service Area[26]

Hospitals in Dyersburg Regional Medical Center's Proposed Service Area	Cardiac Utilization Trends (volume of patients)		
	2010	2011	2012
Baptist - Lauderdale	**0**	**0**	**0**
Diagnostic Cardiac Catheterization ("Cath")	0	0	0
Percutaneous Transluminal Coronary Angioplasty ("PTCA")	0	0	0
Stents	0	0	0
Baptist - Union City	**108**	**37**	**31**
Cath	54	37	31
PTCA	0	0	0
Stents	0	0	0
Dyersburg Regional Medical Center	**376**	**326**	**275**
Cath	376	326	275
PTCA	0	0	0
Stents	0	0	0
Gibson General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0
Stents	0	0	0
Humboldt General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0

[26] Data Sources: Tennessee Department of Health, Joint Annual Report of Hospitals 2010-2012; DRMC internal discharge data for DRMC volume to reflect patients rather than procedures

Stents	0	0	0
Milan General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0
Stents	0	0	0
Grand Total	**1,176**	**2,376**	**303**

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

RESPONSE: The applicant anticipated utilizing two approaches to project the volume of patients for an expansion to offer PCI services. The first approach would entail evaluating transfer data to understand the number of patients that are being transferred from DRMC and those that are leaving the service area without stopping at DRMC to access a higher level of cardiac care that is not currently offered at the hospital. This approach is incorporates patient preferences in terms of the hospital that is primarily utilized for care, and is indicative of referral (self and physician) patterns in the region. The second approach would entail evaluating all payor, patient discharge data by patient origin to understand the utilization of services and market share/volume by providers in the area. Through several interactions with Tennessee Department of Health, it is clear that all payor patient discharge data by patient origin and procedural utilization statistics by age cohort in the service area and the state are not currently available. Due to the inability to access this data, DRMC was not able to conduct the second approach to volume projections.

To project patient volumes for an expansion to offer PCI at DRMC, the applicant analyzed patient transfer data from the hospital records and that of EMS ground and air transfer providers in Dyersburg, Tennessee. The ground transport EMS provider, Dyersburg Regional Emergency Medical Services, services patients in the Dyer County market, whereas the air transport provider is based in Dyersburg, Tennessee and services a 60-mile radius surrounding their location.

Through an evaluation of this transfer data, it is clear that over 1,000 patients left DRMC for cardiovascular care in 2013, with an average of over 900 such transfers per year for the past 3 years. The primary reason that patients would be transferred from DRMC to other facilities for cardiac care is the lack of current capabilities at the hospital. As it relates to cardiac services, PCI and open heart surgery capabilities represent the significant gaps in the current services offered. The volume of ground and air transfers from DRMC for cardiac reasons for the previous three years can be found in Table 18 below.

Table 18 – Volume of Ground and Air Transfers for Cardiac Reasons from DRMC

Mode of Transfer	2011	2012	2013*
EMS Ground Transfer	777	935	1,018
EMS Air Transfer	(not available)	2	3
Total Transfers	**777****	**937**	**1,021**

*EMS Ground Transfer data was annualized for 2 months, and EMS Air Transfer data for 3 months for 2013.
**Total volume of transfers in 2011 is not reflective of EMS Air Transfer volume as it was not available.

In addition to the volume of transfers from DRMC, there are also patients that EMS providers transfer from the area without first stopping at DRMC. This may be due to the patient's history, condition, and/or preference. If an EMS provider suspects a patient is having a heart attack, the provider will bypass DRMC and bring the patient to the nearest hospital that offers PCI services. Upon approval to expand services at DRMC to offer PCI, EMS providers would not need to drive by DRMC if it were the nearest hospital as it would then be able to provide the recognized standard of care to patients experiencing an AMI. Table 19 below displays the volume of patients transported from Dyer County to providers outside of the DRMC service area for cardiac care.

Table 19 – Volume of Patients Transported via EMS from Dyer County for Cardiac Reasons without Receiving Care at DRMC

Mode of Transport	2011	2012	2013*
EMS Ground Transport	102	132	170
EMS Air Transport	(not available)	47	44
Total Transports	**102****	**179**	**214**

*EMS Ground Transfer data was annualized for 2 months, and EMS Air Transfer data for 3 months for 2013.
**Total volume of transports in 2011 is not reflective of EMS Air Transfer volume as it was not available.

It is unclear what services were provided to each of the patients that were transferred in the data above. However, it is reasonable to assume that these patients were transferred to receive a higher level of cardiac care not available at DRMC (e.g., open heart surgery, coronary angioplasty), were deemed too high-risk for DRMC, and/or were managed medically at the receiving hospital. As a conservative approach to this transfer volume, DRMC assumed that just 25% of this patient population received a therapeutic catheterization procedure. Using this assumption, 309 patients transferred from DRMC or Dyer County via EMS providers would have had a PCI procedure performed in 2013. This total does not include the volume of patients that would have received a elective PCI procedure as an outpatient. As is the case with a number of other procedure types, PCI patients receiving PCI procedures continue to migrate to an outpatient setting for their care. Although the rate of inpatient to outpatient PCIs can be 70%/30% respectively, DRMC projected a more conservative estimate of 80%/20% for these volume projections. If we assume that the 309 patients is representative of the 80% complement, then the total inpatient and outpatient PCI patients would total 386 for 2013. With roughly 95% of cardiac interventions occurring in the above 45 age cohort, it can be assumed that 367 of the 386 PCI patients were in this age cohort. It is important to note that this projection does not include patients that reside in other service area Counties that bypassed DRMC as well, due to the EMS transfer data not being available. For this and other reasons, 386 PCIs is deemed to be a conservative estimate of the market volumes in the DRMC service area.

When evaluating the validity of these volume projections, DRMC compared the utilization rate based on these calculations in the service area to that of the country. Table 20 below provides a comparison of utilization rates within the DRMC service area to the nation.

Table 20 – 2013 PCI Utilization Rates in DRMC Service Area and the Nation

2013 Service Area Population	190,186
2013 Estimated PCI Procedures in DRMC Service Area	386
Service Area Utilization Rate for PCI *(per 1,000 population)*	2.03
National Utilization Rate for PCI* *(per 1,000 population)*	**2.80**

*Represents a calculated utilization rate based upon 2011 discharge data derived from AHRQ HCUPNet; Population sourced from U.S. Census data for 2011.

As can be seen from Table 20 above, this approach to projecting PCI volumes is considered reasonable and conservative. Although DRMC anticipates positively impacting the relatively low utilization rates for PCI, the volume projection methodology for a new program at DRMC did not incorporate a growth in the calculated utilization rate. Rather, the rate of 2.03 PCI per 1,000 of the population was applied to the population projections for the area to determine the market potential for a PCI program at DRMC. Therefore, any growth in market potential is based directly on the projected changes in the service area population.

When projecting potential PCI patient volumes, DRMC its ability to attract patients for PCI services would grow over time. Although the vast majority of patients transferred from the area are seeking care at DRMC first, the hospital assumes that it will need to develop a reputation for this new service over time. Therefore, DRMC assumed it would capture one-third of the projected market potential in its first year of operation, growing to one half of the potential by the third year of operation. Details of this volume projection methodology can be found in Table 21 below.

Table 21 – DRMC PCI Volume Projections

	2013		Year 1 (2015)	Year 2 (2016)	Year 3 (2017)
PCI Volume in DRMC Service Area	386		392	395	398
Projected DRMC Market Share	0%		33%	42%	50%
DRMC PCI Volume	0		131	165	199

Historic volume statistics for DRMC are derived from the hospital's internal financial systems, and are case-based (i.e., the volume represent number of patients) rather than procedure-based. Therefore, the projected volumes for diagnostic cardiac catheterization are not double-counted in the projected PCI patient volumes.

Table 22 below displays the applicant's volume statistics and subsequent impact on lab utilization for the past three years with the projected volumes and annual utilization for each of the first two years following the initiation of therapeutic catheterization services at DRMC.

Table 22 – DRMC's Historic and Projected Cardiac Catheterization Volumes and Lab Utilization

Dyersburg Regional Medical Center Utilization Statistics	HISTORIC			PROJECTED	
Service	2011	2012	2013	Year 1	Year 2
Diagnostic Cardiac Cath	376	322	218*	393	494
Therapeutic Cardiac Cath	0	0	0	131	165
Total Adult Cardiac Cath Lab Cases	**376**	**322**	**218**	**524**	**658**
DRMC Cardiac Cath Labs	**1**	**1**	**1**	**1**	**1**
Volume of Weighted Cases Available (2,000 per lab)	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**
DRMC Weighted Cases	**376**	**322**	**218**	**655**	**824**
Lab Utilization	**18.8%**	**16.1%**	**10.9%**	**32.8%**	**41.2%**

* The decline in volume in 2012 and 2013 was due to the departure of a Cardiologist form the medical staff. From May 2012 through August 2013, DRMC had one full-time Cardiologist on active staff at the hospital. In August 2013, a second full-time Cardiologist joined the active staff at DRMC. DRMC anticipates performing volumes at a level that exceeds the state's minimum threshold in 2014 with the additional Cardiology coverage.

Across the country, it is become increasingly difficult for providers, without therapeutic cardiac catheterization capabilities, to attract and retain invasive and/or interventional Cardiologists. This is part of the reason that a number of providers without these capabilities are experiencing an erosion of volumes. In an effort to ensure the continued viability of the cardiac catheterization lab and the Cardiology program at DRMC, it is important that the hospital is allowed to expand its cardiac catheterization program to include therapeutic capabilities.

When analyzing the market potential for PCI services in the DRMC service area, it is clear that the applicant will exceed the minimum volume thresholds of 400 diagnostic/therapeutic cardiac catheterizations with at least 75 being therapeutic within the 1st year of operation with the initiation of a PCI program. For this reason, DRMC meets the market demand requirements for an expansion in capabilities to offer PCI in its service area.

ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**
   - **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**
   - **The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.**

- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**
- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

RESPONSE: The costs for the project are set forth on the Project Cost Chart. The costs for this project are considered reasonable and relatively low due to DRMC already having a cardiac catheterization lab in place with diagnostic capabilities. DRMC will purchase the requisite equipment to advance its capabilities to offer PCI services.

Project Costs Chart	
A. Construction and Equipment acquired by purchase	**Cost**
1. Architectural and Engineering Fees	$0.00
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$147,000.00
3. Acquisition of Site	$0.00
4. Preparation of Site	$0.00
5. Construction Costs	$0.00
6. Contingency Fund	$17,763.00
7. Fixed Equipment (not included in construction costs)	$100,000.00
8. Moveable Equipment (List all equipment over $50,000)	$100,000.00
9. Other (Specify) _____	$0.00
B. Acquisition by gift, donation, or lease	
1. Facility (inclusive of building and land)	$0.00
2. Building only	$0.00
3. Land only	$0.00
4. Equipment (Specify)	$0.00
5. Other (Specify) _____	$0.00
C. Financing Costs and Fees	
1. Interim Financing	$0.00
2. Underwriting Costs	$0.00
3. Reserve for One Year's Debt Service	$0.00
4. Other (Specify)	$0.00
D. Estimated Project Cost (A + B + C)	$364,763.00
E. CON Filing Fee	$3,000.00
F. Total Estimated Project Cost (D + E)	$367,763.00
TOTAL	**367,763.00**

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

☐ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

☐ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

☐ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

☐ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

☑ **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

☐ **F. Other—Identify and document funding from all other sources.**

RESPONSE: See the attached letter from the applicant's Chief Financial Officer in Attachment C2, Economic Feasibility -2 Funding Letter.

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

RESPONSE: DRMC currently offers diagnostic catheterization services, and is proposing an expansion to service capabilities to include therapeutic catheterization services. In order to offer therapeutic catheterization services, DRMC is anticipating an investment of $200,000 into equipment that includes an intravascular ultrasound imaging and fractional flow reserve software, and an uninterrupted power supply for the cardiac catheterization lab to ensure the power supply is not interrupted by a power failure. Additionally, DRMC anticipates spending an additional $164,763 for legal fees, consultant fees, and program implementation support from now until the end of its first year of operation. Thus, the total estimated project cost is $364,763 (excluding CON filing fee). This total investment is considered reasonable, as DRMC does not have to invest in additions or renovations to its existing facility or into new imaging equipment.

4. **Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections**

for the Proposal Only (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

RESPONSE: See Historical and Projected Data Charts in the following pages.

HISTORICAL DATA CHART

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in January.

	Year 2011	Year 2012	Year 2013
A. Utilization Data (Specify unit of measure) Adjusted Admissions	13,109	12,615	11,033
B. Revenue from Services to Patients			
1. Inpatient Services	$177,313,194	$161,453,832	$152,247,675
2. Outpatient Services	$221,867,035	$243,735,249	$242,478,289
3. Emergency Services	$39,556,905	$48,242,459	$53,582,570
4. Other Operating Revenue (Specify)_____	$522,408	$398,483	$351,637
Gross Operating Revenue	**$439,259,542**	**$453,830,023**	**$448,660,171**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$361,201,645	$377,656,922	$377,527,536
2. Provision for Charity Care	$2,143,445	$2,658,744	$1,578,834
3. Provisions for Bad Debt	$11,504,494	$12,376,445	$10,912,316
Total Deductions	**$374,849,584**	**$392,692,111**	**$390,018,686**
NET OPERATING REVENUE	**$64,409,958**	**$61,137,912**	**$58,641,485**
D. Operating Expenses			
1. Salaries and Wages	$26,387,727	$24,305,121	$22,934,196
2. Physician's Salaries and Wages	$0	$0	$0
3. Supplies	$7,436,910	$6,977,615	$6,340,693
4. Taxes	$5,017,623	$5,496,546	$5,425,912
5. Depreciation	$4,787,333	$5,338,108	$3,573,482
6. Rent	$1,395,588	$1,460,407	$1,411,496
7. Interest, other than Capital	$0	$0	$0
8. Other Expenses (Specify)*	$8,949,797	$10,301,713	$8,688,545
Total Operating Expenses	**$53,974,978**	**$53,879,510**	**$48,374,324**
E. Other Revenue (Expenses) – Net (Specify)	$0	$0	$0
NET OPERATING INCOME (LOSS)	**$10,434,980**	**$7,258,402**	**$10,267,161**
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest	$3,357,859	$3,681,870	$4,148,940
Total Capital Expenditures	**$3,357,859**	**$3,681,870**	**$4,148,940**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**$7,077,121**	**$3,576,532**	**$6,118,221**

*Includes Medical Specialists Fees, Purchased Services, Physician Recruiting, Repairs, Marketing, Utilities, and HITECH Incentives

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January.

	Year 1	Year 2
A. Utilization Data (Specify unit of measure) Patients	333	467
B. Revenue from Services to Patients		
1. Inpatient Services	$17,021,709	$22,494,361
2. Outpatient Services	$3,080,886	$4,459,728
3. Emergency Services	$0	$0
4. Other Operating Revenue (Specify) N/A	$0	$0
Gross Operating Revenue	**$20,102,596**	**$26,954,088**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$16,942,794	$22,717,343
2. Provision for Charity Care	$70,416	$94,415
3. Provisions for Bad Debt	$478,856	$642,063
Total Deductions	**$17,492,065**	**$23,453,821**
NET OPERATING REVENUE	**$2,610,530**	**$3,500,268**
D. Operating Expenses		
1. Salaries and Wages	$130,353	$132,666
2. Physician's Salaries and Wages	$438,000	$438,000
3. Supplies	$607,755	$849,295
4. Taxes	$0	$0
5. Depreciation	$40,000	$40,000
6. Rent	$0	$0
7. Interest, other than Capital	$0	$0
8. Other Expenses (Specify) Maintenance Contracts, Database Participation Fees, Contingency, Indirect Expense	$97,198	$125,884
Total Operating Expenses	**$1,313,307**	**$1,585,845**
E. Other Revenue (Expenses) – Net (Specify) Marketing, Implementation Support Expenses	$172,000	$15,000
NET OPERATING INCOME (LOSS)	**$1,125,224**	**$1,899,423**
F. Capital Expenditures		
1. Retirement of Principal	$0	$0
2. Interest	$0	$0
Total Capital Expenditures	**$0**	**$0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXP.	**$1,125,224**	**$1,899,423**

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

RESPONSE: The applicant projects the following charges for the first two years of operation:

	Year 1	Year 2
Average Gross Charge	$60,368	$57,718
Average Deduction from Operating Revenue	$52,529	$50,222
Average Net Charge	$7,839	$7,495

6. **A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

RESPONSE: DRMC does not currently perform PCI services, and therefore, does not have a schedule for charges for these services in its current hospital chargemaster. For this reason, DRMC worked with other hospitals in its health system to develop proposed pricing for PCI services. Proposed charges for PCI procedures by CPT code are included in Table 23 below.

Table 23 – Proposed PCI Charges by CPT Code

CPT 4 (CY14 Final OPPS)	Current Charges	Proposed Charges
92920	N/A	$24,089.42
92921	N/A	$19,271.54
92924	N/A	$35,968.46
92925	N/A	$35,968.46
92928	N/A	$28,557.91
92929	N/A	$28,557.91
92933	N/A	$28,557.91
92934	N/A	$28,557.91
92937	N/A	$28,557.91
92938	N/A	$28,557.91
92941	N/A	$28,557.91
92943	N/A	$28,557.91
92944	N/A	$28,557.91
92978	N/A	$924.00
92979	N/A	$924.00
93571	N/A	$2,958.95
93572	N/A	$2,958.95
C9600	N/A	$34,617.38
C9601	N/A	$34,617.38
C9602	N/A	$34,617.38
C9603	N/A	$34,617.38
C9604	N/A	$34,617.38

C9605	N/A	$34,617.38
C9606	N/A	$34,617.38
C9607	N/A	$34,617.38
C9608	N/A	$34,617.38

The charges included in Table 23 above are reflective of the anticipated charges for PCI procedures, and are not inclusive of all charges involved in the patients' care. The anticipated revenue from the proposed project, including projected PCI and incremental diagnostic catheterization volumes with this expansion of services, will total $2,610,530 in Year 1 and $3,500,268 in Year 2. There will be no anticipated impact on existing patient charges at DRMC. Although there will be no impact on charges, the cost to patients should decrease if DRMC were to offer PCI services, since they would be able to receive a diagnostic catheterization and PCI at one location at one time, minimizing the times the patient would need to undergo a cath procedure. Additionally, the cost of emergency transport would significantly decrease with the lack of need to transport as many patients outside of the area for care. It is important to note that the percentage of patients needing an urgent transfer to surgery during a PCI procedure is less than 0.3%.[27]

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: There are no providers in DRMC's service area that offer PCI services today. Therefore, comparisons cannot be made between DRMC's proposed charges and that of other providers in the service area. However, being that DRMC is part of a health system, the applicant worked with another system hospital, the Regional Hospital of Jackson, to develop proposed charges for this service. At this time, DRMC's proposed charges for PCI services are equal to those at the Regional Hospital of Jackson. It is important to note, however, that charge data for comparative facilities is not publically available at the CPT-code level in Tennessee.

The proposed charges for these procedures are just one aspect of the cost involved in caring for patients with these conditions. Without a provider with PCI capabilities in the service area, patients are forced to leave the service area and travel significant distances to receive treatment. This travel may include traditional modes of transportation in non-urgent situations. However, for patients experiencing a heart attack, it is likely to involve air or ground transport via EMS providers. The cost related to this mode of transport can increase the cost of patient care exponentially and should be factored into the cost of care equation.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: The applicant expects that this project will be cost-effective within the first two years of operation given that projected utilization rates are sufficient to generate profitability. With a limited investment required to expand DRMC's capabilities in its existing cardiac catheterization lab space, the applicant expects to achieve a positive ROI even within the first full year of operation.

[27] Data Source: 2011 ACC guidelines

8. **Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.**

RESPONSE: The applicant projects financial viability will be ensured with a projected positive return on investment ("ROI") within the first full year of service. The projected net operating income for the proposed project in the first full year of operation will be $1,125,224. Dyersburg Hospital Corporation d/b/a Dyersburg Regional Medical Center is providing funding for this project, as well as for the hospital generally. Cash flow support for the project will be provided by Community Health Systems where necessary on an interim basis.

9. **Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

RESPONSE: DRMC currently participates in the Medicare and TennCare programs, and there are no plans to discontinue participation. DRMC cared for over 3,390 Medicaid patients (96% of which are TennCare patients), over 5,000 Medicare patients, and over 630 indigent/self-pay patients in 2013. Overall, this represents 85% of DRMC's patient mix for the year. DRMC is committed to continuing to care for these patients for all services. Table 24 below outlines the state and federal revenue programs in which DRMC participates, and the associated anticipated revenue for incremental diagnostic cardiac catheterizations and PCIs from the first year of the proposed project.

Table 24 – Dyersburg Regional Medical Center's State and Federal Revenue Programs

State & Federal Revenue Programs	Year 1 Estimated Revenue	Year 1 % of Total Project Revenue
Medicaid/TennCare	$87,985	3%
Medicare	$1,950,257	75%
Medically Indigent	$83,126	3%

DRMC anticipates roughly 85% of its patient mix for this service to include Medicaid/TennCare, Medicare, and indigent/self-pay patients. The % of revenue coming from the Medicaid/TennCare and Medically Indigent patients in Table 24 above is reflective of the relatively lower reimbursement rates of associated with these insurance programs.

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

RESPONSE: Dyersburg Hospital Corporation d/b/a DRMC is audited once every 3-4 years, and is schedule for its audit in 2014. Therefore, no recent audited financial statements exist. A copy of the un-audited financials for 2013 are attached as Attachment C, 10 Financial Statements.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

RESPONSE: As part of the determination to apply for a CON to provide therapeutic cardiac catheterization services, the leadership team at DRMC considered two alternatives to the project including: 1) Status Quo/Do Nothing, or to 2) Develop an Enhanced Network of Care for PCI. A summary of the practicality of each alternative can be found below:

1) **Status Quo/Do Nothing** – The possibility exists for DRMC to continue to provide only diagnostic cardiac catheterization services to the community it serves. However, as therapeutic cardiac catheterization services have been proven safe in labs without cardiac surgery on-site, it became clear that DRMC is currently NOT able to offer the recognized standard of care for the treatment of AMI to its community. Rather than be treated at DRMC, patients are transported via helicopter or ambulance to a hospital that resides outside of DRMC's service area. This creates delays in patient care causing additional damage to a patient's heart muscle, increases the risk associated with the patient's survival, and increases the cost of care. The cost associated with emergency ground and air transport from the DRMC market is roughly $2,000 and $30,000 per patient, respectively (depending on the retrieval and destination locations). A component of DRMC's mission statement involves ensuring quality care is delivered to the patients the hospital serves. With that in mind, a decision to NOT provide the recognized standard of care to DRMC's patient base was simply not acceptable. By providing this service at DRMC, the cost of care will be reduced while the quality of patient care would be improved. Therefore, this alternative was rejected as it is not considered a viable option.

2) **Develop an Enhanced Network of Care for PCI** – DRMC is part of Community Health Systems ("CHS") with headquarters in Franklin, Tennessee. Currently, CHS includes 132 hospitals in 29 states, with 11 based in the state of Tennessee. Nationally, a number of health systems are evaluating options to develop a network of care to serve the complex needs of their communities. Relative to cardiovascular services, a number of systems are evaluating whether to reduce the number of hospitals that offer open heart surgical services, while maintaining the therapeutic cardiac catheterization capabilities to create a 'hub and spoke' network. When changes like this are made, the hospitals that no longer offer cardiac surgery services continue to offer PCI to ensure the standard of care is available to their communities. Although DRMC is part of a larger health system, the closest system hospital, Regional Hospital of Jackson, is 47.8 miles from DRMC and a 51-minute drive. Additionally, the closest non-CHS hospital to DRMC that offers therapeutic cardiac catheterization services, Jackson-Madison County General Hospital is 48.4 miles from DRMC and a 55-minute drive. Given the distance and related delays to treatment involved, the development of an enhanced network to effectively provide this service to DRMC patients was not deemed acceptable. If DRMC pursued this option, the emergent ground and air transport costs would still be added on to the cost of care, thus increasing the cost necessarily to deliver the standard of care to the patients. Additionally, the time involved in transport would still exist, thus negatively impacting the quality of care offered when

compared to offering the service at DRMC. Therefore, this alternative was rejected and is not considered a viable option.

In an effort to provide the standard of care to its patients, while reducing the cost of care to the patients, DRMC submits that the best option involves offering therapeutic cardiac catheterization services at DRMC.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: The DRMC proposal for advancement to offer therapeutic cardiac catheterization services does not include new construction. Rather, DRMC will provide this service in the existing space where the hospital provides its diagnostic cardiac catheterization service. Given existing patient volumes and projections based upon the addition of this service, DRMC will not require additional cardiac catheterization lab space for the foreseeable future. If there is a time when patient volumes dictate the necessity for additional cardiac catheterization lab space, DRMC will complete a separate certificate of need application.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

   RESPONSE: Please see the list in Attachment C, (III) (1) Contractual Agreements.

2. **Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

   RESPONSE: It is important to note that all payer patient origination data is not available at a ZIP Code or County level through the Tennessee Department of Health. In the absence of this data, DRMC is unable to determine the exact number of patients leaving its service area for therapeutic cardiac catheterization at a particular provider that offers the service. Without this data, DRMC is limited to simply evaluating the number of patients that are transferred from DRMC to another provider for a higher level of cardiovascular care (e.g., PCI, open heart, etc.). Patients that bypass DRMC via emergency transport or other means due to the hospital not offering the service would not be included in this transfer data.

   When evaluating the service area for PCI services, DRMC reviewed its historical discharge data. The service area for PCI services includes six Counties in Tennessee, and one County in Missouri. Although DRMC cares for some patients residing outside of this proposed service area, it accounts for less than 3% of their total inpatient discharges in 2013. Therefore, DRMC is confident that this area is representative of its market for therapeutic cardiac catheterization patients in this proposal.

Using the 2012 Joint Annual Reports from the Tennessee Department of Health, the hospitals located in DRMC's service area are listed by County in Table 25 below. The table also indicates each hospital's cardiac catheterization capabilities.

Table 25 – Dyersburg Regional Medical Center Proposed Service Area Hospitals & Cardiac Catheterization Services[28]

County Name	Hospital Name	Diagnostic Cardiac Catheterization Services	Therapeutic Cardiac Catheterization Services
Dyer County	Dyersburg Regional Medical Center	Yes	No
Crocket County	*No hospitals located within the County*	N/A	N/A
Gibson County	Gibson General Hospital	No	No
	Humboldt General Hospital	No	No
Lake County	*No hospitals located within the County*	N/A	N/A
Lauderdale County	Lauderdale Community Hospital	No	No
Obion County	Baptist Memorial Hospital – Union City	Yes	No
Pemiscot County, Missouri	Pemiscot County Memorial Hospital	No	No

As noted in Table 25 above, currently none of the hospitals residing in the DRMC service area offer therapeutic cardiac catheterization, and just one other hospital (Baptist Memorial Hospital – Union City) offers diagnostic cardiac catheterization services. Therefore, the approval of this application to allow DRMC to offer therapeutic cardiac catheterization would not create a duplication of services, nor competition with providers that exist in the service area. Additionally, the addition of this service at DRMC will have no impact on the utilization of services by providers located within the service area, as they do not currently offer this service.

Due to a lack of access to therapeutic cardiac catheterization services within the service area, patients must travel outside of their home County to seek this level of care from providers in other markets. For this reason, it can be reasonably assumed that the addition of a new service at DRMC will impact the utilization of this service at providers located outside of this market. However, the actual impact upon each provider is difficult to determine without market data noting the patient's origin at a ZIP Code or County level. Additionally, given the relatively high mortality rate for cardiovascular disease in the DRMC service area, it is likely that there are also patients that are currently not seeking or not receiving the appropriate level of care in a timely fashion. Therefore, a new therapeutic catheterization program at DRMC will increase access to care in the area, and enable DRMC to meet the volume projections and improve the healthcare for area residents, while

[28] Data Source: 2012 Joint Annual Reports from the Tennessee Department of Health

likely having a marginal effect on the utilization of services by providers located outside of the service area.

3. **Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.**

RESPONSE: DRMC commits to providing an appropriate staffing pattern to support a best-practice approach to care for both the emergent and elective PCI patient population. DRMC will ensure a full team complement of expert personnel consisting of at least four full-time team members available 24/7/365 in order to care for the STEMI/AMI patient population as part of an "on-call" team. This team will include a complement of staff including registered nurse(s), registered radiologic staff, and/or registered cardiovascular technologist(s) staff. The anticipated staffing pattern for those providing patient care for therapeutic cath at DRMC is set forth in Table 26 below.

Table 26 – Staffing Pattern for Therapeutic Catheterization Services at Dyersburg Regional Medical Center

Dyersburg Regional Medical Center Cardiac Cath Lab Staff	Current	Year 1	Year 2
Registered Nurse (RN)	3	4	4
Cardiovascular Radiology Technician (CVT)	1.5	2	2

The salaries for these positions will be comparable to those paid for personnel working in similar positions today at DRMC, within the State of Tennessee, and in the west Tennessee region, as illustrated in Table 27 below.

Table 27 – Comparison of Dyersburg Regional Medical Center Clinical Salaries to Prevailing Wage Patterns

Staff	DRMC		west Tennessee		State of Tennessee	
	Hourly	Annual	Hourly Mean	Annual Mean	Hourly Mean	Annual Mean
Registered Nurse (RN)[29]	$26.78	$55,702	$25.10	$52,220	$26.85	$55,800
Cardiovascular Radiology Technician (CVT)[30]	$18.43	$39,484	$20.08	$41,770	$23.15	$48,150

[29] TN Department of Labor & Workforce Development, Employment Security Division, Labor Market Information unit. Published July 2013. Statewide = http://www.tn.gov/labor-wfd/wages/2013/PAGE0018.HTM; West TN = http://www.tn.gov/labor-wfd/wages/2013/PAGE0329.HTM

[30] TN Department of Labor & Workforce Development, Employment Security Division, Labor Market Information unit. Published July 2013. Statewide = http://www.tn.gov/labor-wfd/wages/2013/tennessee.pdf; West TN = http://www.tn.gov/labor-wfd/wages/2013/west.pdf

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

RESPONSE: The applicant is confident that the human resources necessary to provide services for this proposal will be available and accessible to DRMC. The applicant commits to providing exceptional patient care and will utilize the expertise and experience of the cardiac catheterization staff having in-depth knowledge and "hands-on" experience in caring for a PCI patient population. DRMC intends to staff for 24/7/365 "on-call" for the STEMI/AMI patient population. Each clinical staff member of the cardiac catheterization team will meet all licensure requirements and will possess current state licensure as either a registered nurse (RN) and/or registered radiology technologist.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.**

RESPONSE: DRMC is a licensed Tennessee hospital, duly licensed by the Tennessee Board for licensing Healthcare Facilities. The applicant has reviewed and understands all licensing certification requirements for its medical and clinical staff as required by the State of Tennessee. It has appropriate quality assurance policies and programs, as well as utilization review policies and programs and an extensive staff education program. As previously mentioned, the applicant is Joint Commission accredited. The applicant's accreditation is attached. See Attachment C, (III) (5) The Joint Commission Accreditation .

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).**

RESPONSE: Applicant provides training and education for student registered nurses, licensed practical nurses, radiology technicians and emergency medical service providers through a relationship with Dyersburg State Community College and Jackson State Community College.

7. **(a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

RESPONSE: Applicant has reviewed and understands the licensure requirements of the Department of Health, and all applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

RESPONSE:
Licensure: Applicant is licensed by the Tennessee Board for Licensing Healthcare Facilities.

Accreditation: Applicant is fully accredited by the Joint Commission.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE: Applicant is in good standing with the Tennessee Board for Licensing Healthcare Facilities and The Joint Commission. Requested copies of applicant's license is attached as Attachment C, (III) 7 (c)(1)DRMC Hospital License.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE: No Department of Health survey has been conducted in several years, and the hospital could not locate a copy of a statement of deficiencies. All deficiencies cited in the most recent Joint Commission survey have been corrected and accepted by the accrediting agency. All cited deficiencies were relatively minor. See Attachment C, (III) 7 (d) Joint Commission Survey.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

   RESPONSE: There are no final orders or judgments against any professional licenses held by applicant or any person or entity as described in this question.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

   RESPONSE: There are no final civil or criminal judgments for fraud or theft against any person or entity as described in this question.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

    RESPONSE: As it currently does for all services, DRMC will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of PCI patients treated, the number and type of procedures performed, and other data as required.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

A Publisher's Affidavit has been requested and will be submitted in a timely manner when received by the applicant.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c):
June 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

PHASE		DAYS REQUIRED	ANTICIPATED DATE (Month/Year)
1.	Architectural and engineering contract signed		
2.	Construction documents approved by the Tennessee Department of Health		
3.	Construction contract signed		
4.	Building permit secured		
5.	Site preparation completed		
6.	Building construction commenced		
7.	Construction 40% complete		
8.	Construction 80% complete		
9.	Construction 100% complete (approved for occupancy		
10.	*Issuance of license	225	January 15, 2015
11.	*Initiation of service	225	January 15, 2015
12.	Final Architectural Certification of Payment		
13.	Final Project Report Form (HF0055)	285	March 15, 2015

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

List of Attachments

Attachment A, 4 Organizational Documentation

Attachment A, 6 Deed

Attachment B (III) (A) DRMC Plot Plan

Attachment B (IV) DRMC Cardiac Cath Lab Floor Plan

Attachment C Specific Cardiac Cath Criteria (3) Transfer Agreements

Attachment C (III) Proposed Service Area Map

Attachment C2, Economic Feasibility -2 Funding Letter

Attachment C, 10 Financial Statements

Attachment C, (III) (1) Contractual Agreements

Attachment C, (III) (5) The Joint Commission Accreditation

Attachment C, (III) 7 (c)(1)DRMC Hospital License

Attachment C, (III) 7 (d) Joint Commission Survey

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

MAR 14 '14 AM 10:20

STITES & HARBISON, PLLC
STE 800
401 COMMERCE ST
NASHVILLE, TN 37219-2490

Request Type: Certified Copies
Request #: 122542

Issuance Date: 03/10/2014
Copies Requested: 1

Document Receipt

Receipt # : 1359756 Filing Fee: $20.00

Payment-Check/MO - STITES & HARBISON, PLLC, NASHVILLE, TN $20.00

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that **DYERSBURG HOSPITAL CORPORATION**, Control # 435828 was formed or qualified to do business in the State of Tennessee on 10/29/2002. DYERSBURG HOSPITAL CORPORATION has a home jurisdiction of TENNESSEE and is currently in an Active status.

Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
4639-0813	10/29/2002	Initial Filing
4657-0611	11/22/2002	Assumed Name
4686-0478	01/02/2003	Assumed Name
4686-0480	01/02/2003	Assumed Name
4686-0482	01/02/2003	Assumed Name
4956-0500	11/06/2003	Registered Agent Change (by Entity)
5195-1341	07/27/2004	Assumed Name
5195-1342	07/27/2004	Assumed Name
5195-1343	07/27/2004	Assumed Name
5195-1344	07/27/2004	Assumed Name
5195-1345	07/27/2004	Assumed Name
5195-1346	07/27/2004	Assumed Name Change
5195-1347	07/27/2004	Assumed Name Change
5239-1685	09/20/2004	Registered Agent Change (by Entity)

Attachment A, 4 Organizational Documentation

The attached document(s) was/were filed in this office on the date(s) indicated below:

Reference #	Date Filed	Filing Description
5740-1000	03/29/2006	2005 Annual Report (Due 04/01/2006)
5812-0104	06/19/2006	Assumed Name
6012-0287	03/30/2007	2006 Annual Report (Due 04/01/2007)
6176-0300	01/02/2008	Assumed Name Renewal
6176-0301	01/02/2008	Assumed Name Renewal
6176-0302	01/02/2008	Assumed Name Renewal
6281-2365	04/04/2008	Registered Agent Change (by Entity)
6320-1085	05/22/2008	Assumed Name
6394-3152	11/05/2008	Assumed Name Cancellation
6394-3154	11/05/2008	Assumed Name Cancellation
6394-3156	11/05/2008	Assumed Name Cancellation
6394-3158	11/05/2008	Assumed Name Cancellation
6394-3160	11/05/2008	Assumed Name Cancellation
6394-3162	11/05/2008	Assumed Name Cancellation
6394-3164	11/05/2008	Assumed Name Cancellation
6533-3035	05/13/2009	Assumed Name
A0112-0155	03/26/2012	2011 Annual Report (Due 04/01/2012)
7204-1306	05/13/2013	Assumed Name Renewal

CHARTER

OF

DYERSBURG HOSPITAL CORPORATION

The undersigned person, having capacity to contract and acting as the incorporator of a corporation for profit under the Tennessee Business Corporation Act, hereby adopts the following Charter for such corporation:

1. The name of the corporation is: Dyersburg Hospital Corporation.

2. The corporation's initial registered office is located at 2908 Poston Avenue, Nashville, Tennessee 37203, County of Davidson. The initial registered agent at that office is Corporation Service Company.

3. The name and address of the incorporator is Kimberly A. Wright, Suite 400, 155 Franklin Road, Brentwood, Tennessee 37027.

4. The address of the principal office of the corporation shall be Suite 400, 155 Franklin Road, Brentwood, Tennessee 37027.

5. The corporation is for profit.

6. The corporation is authorized to issue one thousand (1,000) shares of common stock, no par value.

7. The business and affairs of the corporation shall be managed by a Board of Directors:

a. The number of directors and their term shall be specified in the Bylaws of the corporation;

b. Whenever the Board of Directors is required or permitted to take any action by vote, such action may be taken without a meeting on written consent setting forth the action so taken, signed by all of the directors, indicating each signing director's vote or abstention. The affirmative vote of the number of directors that would be necessary to authorize or to take such action at a meeting is an act of the Board of Directors;

c. Any or all of the directors may be removed with cause by a majority vote of the entire Board of Directors.

8. To the fullest extent permitted by the Tennessee Business Corporation Act as the same may be amended from time to time, a director, officer or incorporator of the corporation shall not be liable to the corporation or its shareholders for monetary damages for breach of fiduciary duty in such capacity. If the Tennessee Business Corporation Act is amended, after approval by the shareholders of this provision, to authorize corporate action further eliminating or limiting the personal liability of a director, officer or incorporator then the liability of a director, officer or incorporator of the corporation shall be eliminated or limited to the fullest extent permitted by the Tennessee Business Corporation Act, as so amended from time to time. Any repeal or modification of this Section 8 by the shareholders of the corporation shall not adversely affect any right or protection of a director, officer or incorporator of the corporation existing at the time of such repeal or modification or with respect to events occurring prior to such time.

9. Each person who was or is made a party or is threatened to be made a party to or is otherwise involved in any action, suit or proceeding, whether civil, criminal, administrative or investigative and whether formal or informal (hereafter a "proceeding"), by reason of the fact that he or she is or was a director, officer or incorporator of the corporation or is or was serving at the request of the corporation as a director, officer, manager or incorporator of another corporation or as a partner or trustee of a partnership, joint venture, limited liability company, trust or other enterprise, including service with respect to employee benefit plans (hereinafter an "Indemnitee"), whether the basis of such proceeding is alleged action in an official capacity as a director, officer, manager or incorporator or in any other capacity while serving as a director, officer, manager or incorporator, shall be indemnified and held harmless by the corporation to the fullest extent authorized by the Tennessee Business Corporation Act, as the same may be amended (but, in the case of any such amendment, only to the extent that such amendment permits the corporation to provide broader indemnification rights than such law permitted the corporation to provide prior to such amendment), against all expense, liability and loss (including but not limited to counsel fees, judgments, fines, ERISA, excise taxes or penalties and amounts paid in settlement) reasonably incurred or suffered by such Indemnitee in connection therewith and such indemnification shall continue as to an Indemnitee who has ceased to be a director, officer, manager or incorporator and shall inure to the benefit of the Indemnitee's heirs, executors and administrators. The right to indemnification conferred in this Section 9 shall be a contract right and shall include the right to be paid by the corporation the expenses incurred in any such proceeding in advance of its final disposition (hereinafter an "advancement of expenses"); provided, however, that an advancement of expenses incurred by an Indemnitee shall be made only upon delivery to the corporation of an undertaking, by or on behalf of such Indemnitee, to repay all amounts so advanced if it shall ultimately be determined by final judicial decision from which there is no further right to appeal that such Indemnitee is not entitled to be indemnified for such expenses under this Section 9 or otherwise, the Indemnitee furnishes the corporation with a written affirmation of his or her good faith belief that he or she has met the standards for indemnification under the Tennessee Business Corporation Act, and

a determination is made that the facts then known to those making the determination would not preclude indemnification.

The corporation may indemnify and advance expenses to an officer, employee or agent who is not a director to the same extent as to a director by specific action of the corporation's Board of Directors or by contract.

The rights to indemnification and to the advancement of expenses conferred in this Section 9 shall not be exclusive of any other right that any person may have or hereafter acquire under any statute, this Charter, Bylaw, agreement, vote of stockholders or disinterested directors or otherwise, and the corporation is hereby permitted to grant additional rights to indemnification and advancement of expenses, to the fullest extent permitted by law, by resolution of directors, or an agreement providing for such rights.

The corporation may maintain insurance, at its expense, to protect itself and any director, officer, manager, employee or agent of the corporation or of another corporation, partnership, joint venture, limited liability company, trust or other enterprise against any expense, liability or loss, whether or not the corporation would have the power to indemnify such person against such expense, liability or loss under the Tennessee Business Corporation Act.

Dated this 28th day of October, 2002.

Kimberly A. Wright

Kimberly A. Wright, Incorporator

S:\Acquisitions\Methodist\DyersburgCharter.wpd

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Dyersburg Hospital Corporation

2. The state or country of incorporation is Tennessee

3. The corporation intends to transact business in Tennessee under an assumed corporate name

4. The assumed corporate name the corporation proposes to use is
Dyersburg Regional Medical Center

[**NOTE:** The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

November 20, 2002
Signature Date

Assistant Secretary
Signer's Capacity

Dyersburg Hospital Corporation
Name of Corporation

Kimberly A. Wright
Signature

Kimberly A. Wright
Name (typed or printed)

SS-4402 (Rev. 4/01) Filing Fee: $20 RDA1720

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Dyersburg Hospital Corporation

2. The state or country of incorporation is Tennessee

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
West Tennessee Regional Private Healthcare Services

[NOTE: The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

12-31-02
Signature Date

Dyersburg Hospital Corporation
Name of Corporation

Assistant Secretary
Signer's Capacity

Sherry A. Connelly
Signature

Sherry A. Connelly
Name (typed or printed)

SS-4402 (Rev. 4/01) Rev:30 RDA1720

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR REGISTRATION OF ASSUMED CORPORATE NAME

For Office Use Only

Pursuant to the provisions of Section 48-14-101(d) of the Tennessee Business Corporation Act or Section 48-54-101(d) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Dyersburg Hospital Corporation

2. The state or country of incorporation is Tennessee

3. The corporation intends to transact business in Tennessee under an assumed corporate name.

4. The assumed corporate name the corporation proposes to use is
West Tennessee Home Health Agency

[NOTE: The assumed corporate name must meet the requirements of Section 48-14-101 of the Tennessee Business Corporation Act or Section 48-54-101 of the Tennessee Nonprofit Corporation Act.]

12-31-02
Signature Date

Assistant Secretary
Signer's Capacity

Dyersburg Hospital Corporation
Name of Corporation

Sherry A. Connelly
Signature

Sherry A. Connelly
Name (typed or printed)

SS-4402 (Rev. 4/01) 6e:90 RDA1720

THIS INSTRUMENT PREPARED BY:

David C. Dillender, Esq.
GREENEBAUM DOLL & McDONALD PLLC
700 Two American Center
3102 West End Avenue
Nashville, Tennessee 37203
615-760-7170

When recorded, return to:
First National Financial Title
15 Century Blvd., Suite 101
Nashville, TN 37214

The actual consideration for this transfer, or the value of the property transferred, whichever is greater, is $ 27,654,000, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

_____, VP
_____, Affiant

Subscribed and sworn to before me this 4 day of December, 2003.

_____
Notary Public

My commission expires: 9/22/2003

NOTARY PUBLIC AT LARGE
SUSAN B. McDONALD
SHELBY COUNTY, TENNESSEE
MY COMMISSION EXPIRES SEPT. 22, 2003

Address of New Owner as Follows:	**Send Tax Bills To:**	**Map/Parcel Numbers:**
Dyersburg Hospital Corporation c/o CHS/Community Health Systems, Inc. 155 Franklin Road, Suite 400 Brentwood, Tennessee 37027	Dyersburg Hospital Corporation c/o CHS/Community Health Systems, Inc. 155 Franklin Road, Suite 400 Brentwood, Tennessee 37027	088F B 011.00 088F B 015.00 088K B 001.00

SPECIAL WARRANTY DEED

FOR AND IN CONSIDERATION of the sum of Ten Dollars ($10.00), and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, **METHODIST HEALTHCARE-DYERSBURG HOSPITAL** (f/k/a Parkview Hospital and Parkview Methodist Medical Center), a Tennessee non-profit corporation ("Grantor"), has this day bargained, sold, transferred and conveyed, and by these presents does bargain, sell, transfer and convey unto **DYERSBURG HOSPITAL CORPORATION**, a Tennessee corporation ("Grantee"), the following described property, being situated and located in the City of Dyersburg, County of Dyer, Tennessee, to-wit:

See **Exhibit "A"** attached hereto and incorporated herein by reference.

This conveyance is made subject only to the matters set forth on **Exhibit "B"** attached hereto and incorporated herein by reference.

Source of Grantor's interest are deeds recorded in Book 217, Page 306, Book 422, Page 3, and Book 351, Page 271, Register's Office of Dyer County, Tennessee.

Dyersburg - Parcels 1,2&4

as the "Property") unto Grantee, its successors and assigns in fee simple forever.

Grantor covenants that Grantor is lawfully seized and possessed of the Property; that it has full power and lawful authority to sell and convey the Property; that the title to the Property is free, clear and unencumbered except as aforesaid; and Grantor will forever warrant and defend the title to the Property against all persons lawfully claiming the same from, through or under Grantor, but not otherwise.

The words "Grantor" and "Grantee" shall include their respective successors and assigns where the context requires or permits.

IN WITNESS WHEREOF, Grantor has caused this instrument to be executed on this 1st day of ~~December~~ January, 2002/3.

METHODIST HEALTHCARE-DYERSBURG HOSPITAL

By: Chris McLean

Name: Chris McLean

Title: Treasurer

("Grantor")

STATE OF TENNESSEE)
) SS:
COUNTY OF Shelby)

Before me, a Notary Public in and for said state and county, personally appeared Chris McLean, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Treasurer of **Methodist Healthcare-Dyersburg Hospital,** a Tennessee non-profit corporation, the within named bargainor, and that he/she being authorized to do so, executed the foregoing Special Warranty Deed for the purposes contained on behalf of the corporation.

Witness my hand and seal this 1st day of ~~December~~ January, 2002/3.

My Commission expires: 9/22/2003.

Susan B. McDonald

NOTARY PUBLIC

SUSAN B. McDONALD
NOTARY PUBLIC AT LARGE
SHELBY COUNTY, TENNESSEE
MY COMMISSION EXPIRES SEPT. 22, 2003

NAS:535156.1

88K B 1.00

DYER COUNTY
ASSESSOR'S OFFICE 1.00
MAP 88F GP B PL 15.00
COMPLETE PARTIAL 2
VAC ASSESSOR
IMP CLERK

and being in the 4th Civil District of Dyer County, Tennessee, and being more particularly described as follows:

BEGINNING at the intersection of the West right-of-way margin of Woodlawn Avenue and the North right-of-way margin of Tickle Street, City of Dyersburg, Dyer County, Tennessee; thence South 86°08'00" West along the North right-of-way margin of Tickle Street a distance of 656.00 feet; thence leaving Tickle Street North 03°59'57" West a distance of 370.33 feet; thence South 88°10'00" West a distance of 291.12 feet to the East right-of-way margin of Parr Avenue; thence North 04°38'50" West along the East right-of-way margin of Parr Avenue a distance of 405.21 feet to the center of Wilkinson Drive; thence North 87°45'00" East along the center of Wilkinson Drive a distance of 801.25 feet; thence leaving Wilkinson Drive South 04°03'00" East a distance of 248.07 feet; thence North 87°45'00" East a distance of 150.00 feet to the West right-of-way margin of Woodlawn Avenue; thence South 04°03'00" East along the West right-of-way margin of Woodlawn Avenue a distance of 27.28 feet; thence leaving Woodlawn Avenue South 85°55'00" West a distance of 89.00 feet; thence South 03°56'00" East a distance of 107.80 feet; thence North 86°11'00" East a distance of 89.22 feet to the West right-of-way margin of Woodlawn Avenue; thence South 04°03'00" East along the West right-of-way margin of Woodlawn Avenue a distance of 24.00 feet; thence leaving Woodlawn Avenue South 86°10'00" West a distance of 142.22 feet; thence South 03°45'00" East a distance of 133.10 feet; thence North 85°47'00" East a distance of 142.93 feet to the West right-of-way margin of Woodlawn Avenue; thence South 04°03'00" East along the West right-of-way margin of Woodlawn Avenue a distance of 219.29 feet to the Point of Beginning.

SUBJECT TO: The South Half (S ½) of Wilkinson Drive lying along the North boundary of the above described property.

lying and being situated in the Fourth Civil District of Dyer County, Tennessee, and within the corporate limits of the City of Dyersburg, and being more particularly described as follows:

BEGINNING at a stake in the south right of way line of Tickle Street, said stake being the northeast corner of the within described lot and the Northwest corner of Lot No. 36 of the East Parkview Addition to the City of Dyersburg now owned by Dyersburg Medical Building, Inc., thence South 03°58'44" East with the West line of said Lot No. 36 of the East Parkview Addition 149.99 feet to a 1 inch pipe found at the Southwest corner of Lot No. 36, the Northwest corner of Lot No. 1 of said East Parkview Addition and the northeast corner of a lot conveyed unto Jerry Marshall Jernigan by the 1st Hillcrest Company by deed recorded in Deed Book 140, Page 184, in the Register's Office for Dyer County, Tennessee; thence South 86°49'03" West with Jerry Jernigan's and 1st Hillcrest Company, Inc.'s north line 316.37 feet to a 1 inch iron pipe found; thence North 08°02'42" East 205.96 feet to a 1 inch iron pipe found in the South right of way line of Tickle Street, said stake being South 81 deg. 45' East 100 feet from the intersection of the east right of way line of Parr Avenue with the South right of way line of Tickle Street; runs thence South 82°26'04" East with the South right of way line of Tickle Street 279.08 feet to the Point of Beginning.

Methodist Healthcare – Dyersburg Hospital
Dyersburg, Dyer County, Tennessee

1. All assessments and taxes for the year 2003 and all subsequent years, which are not yet due and payable.

2. Easement for vehicular and pedestrian ingress and egress as provided in Warranty Deed from Dyer County, Tennessee to Parkview Hospital as recorded in Book 217, Page 306, Official Records of Dyer County, Tennessee.

3. Easements for the purpose of constructing, laying, building and maintaining sanitary sewer line and water line granted the City of Dyersburg by instrument dated 2/7/27 and recorded in Deed Book 51, Page 74, and by instrument recorded in Deed Book 53, Page 478, being the same as shown on plat recorded in Plat Book 4, Page 38, in the Register's Office of Dyer County, Tennessee and as shown on survey dated November 14, 2002, prepared by Christopher Denham, Tenn. Reg. No. 2000, as revised December 24, 2002 **(Parcel 1)**.

4. Easement 10' wide along the north line of the 8.36 acre tract designated as the "Proposed Hospital Site" on the plat of East Parkview Addition recorded in Plat Book 2, Page 17, being the same as shown on plat recorded in Plat Book 4, Page 38, in the Register's Office of Dyer County, Tennessee, and as shown on the Survey dated November 14, 2002, prepared by Christopher Denham, Tenn. Reg. No. 2000, as revised December 24, 2002. **(Parcel 1)**.

5. Perpetual, non-exclusive easements for ingress and egress in Warranty Deed recorded 8/15/94 in Book 289, Page 433, Official Records of Dyer County, Tennessee, as shown on survey dated November 14, 2002 by Christopher S. Denham, Tenn. Reg. No. 2000, as revised December 24, 2002. **(Parcel 1)**.

6. Reciprocal License Agreement by and between Methodist Hospital of Dyersburg, Inc., and Wesley of the South, Inc., a Tennessee not-for-profit corporation, for the pedestrian and vehicular ingress and egress as recorded 8/15/94 in Book 289, Page 436, Official Records and Assigned to The Health, Educational and Housing Facilities Board of Dyer County, Tennessee in Book 290, Page 440, Official Records of said County. **(Parcel 1)**.

7. Easement for Utility Purposes in favor of the City of Dyersburg as recorded 8/29/90 in Book 268, Page 283, Official Record of Dyer County, Tennessee,

8. Terms, conditions, agreements, covenants, obligations and limitations contained in unrecorded leases.

9. The following matters shown on the Survey of Methodist Healthcare – Dyersburg Hospital dated November 14, 2002 by Christopher S. Denham, Tenn. Reg. No. 2000, as revised December 24, 2002:

PARCEL 1

a. Overhead electrical wires extend from premises onto Woodlawn Avenue. Possible rights and easements of others to enter onto premises for purpose of repairing and/or maintaining same may be created thereby;
b. Parking extends onto Tickle Street;
c. Helipad lies on Parcel 1, within lines. Possible rights and easements of others may be created thereby;
d. One (1)-story metal building encroaches into minimum setback up to 1.8 feet;
e. Methodist Healthcare-Dyersburg Hospital main building encroaches into minimum setback by 11.2 feet on the easterly side of building;
f. Parking spaces encroach onto lands of Wesley of the South, Inc., described in Deed Book 289 page 433, adjoining the subject premises on the Southwest; and
g. Parking spaces located on lands of Dyer County Tennessee Health Department adjoining on the East, encroach onto subject premises.

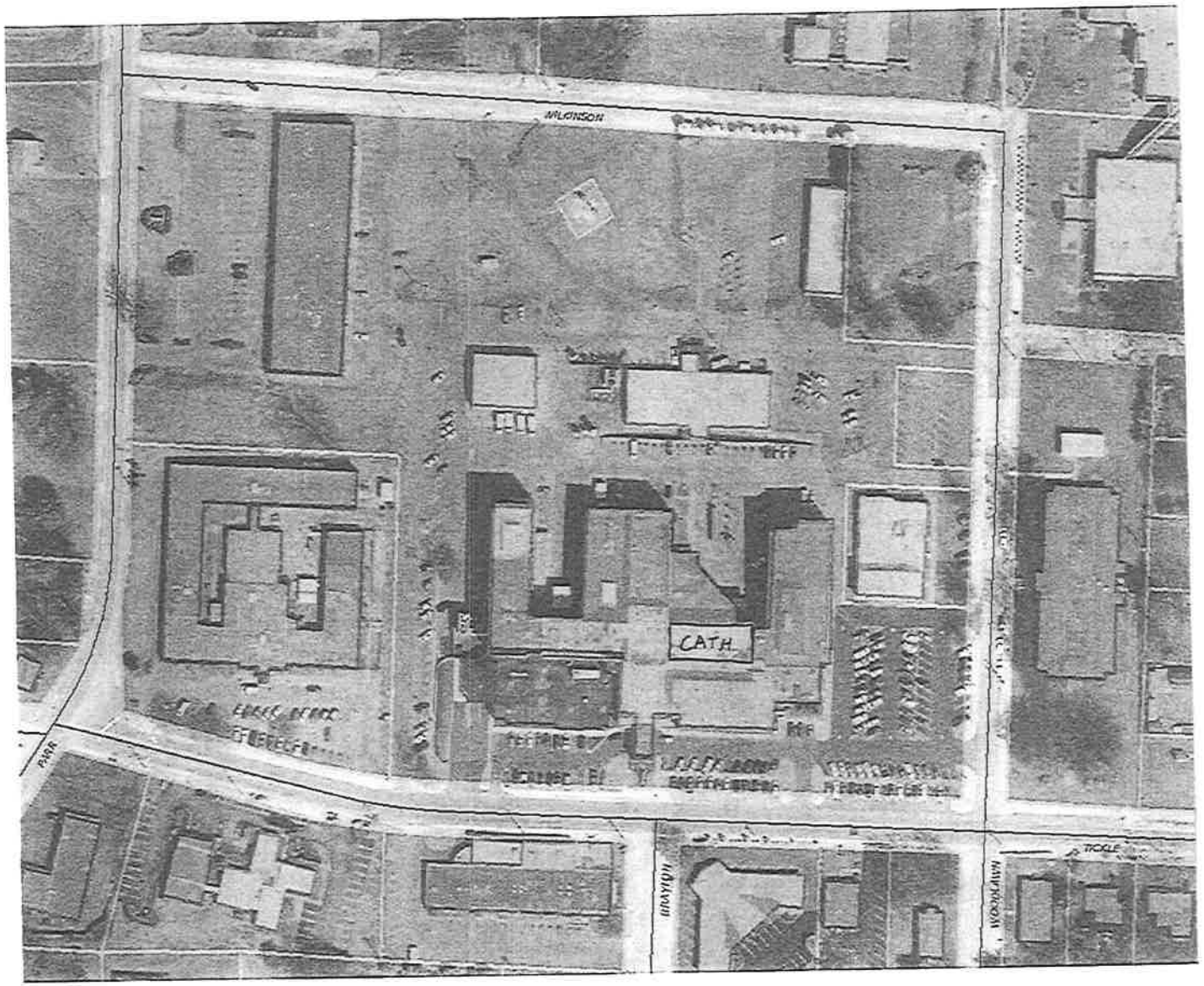
PARCEL 2

h. Driveway extends onto Tickle Street;
i. Overhead electrical wires extend onto premises adjoining on the South and East and onto Tickle Street. Possible rights and easements of others to enter onto premises for purpose of repairing and/or maintaining same may be created thereby; and
j. Jackson Clinic building encroaches into minimum setback by 6.5 feet, more or less, on the northerly side of building.

Danny Fowlkes, Register
Dyer County Tennessee
Rec #: 30126 Instrument 200300184
Rec'd: 35.00 MBk: 33 Pg 273
State: 02319.80
Clerk: 1.00 Recorded
EDP: 2.00 1/9/2003 at 9:41 am
Total: 02357.80 in Record Book
485 Pages 56-62

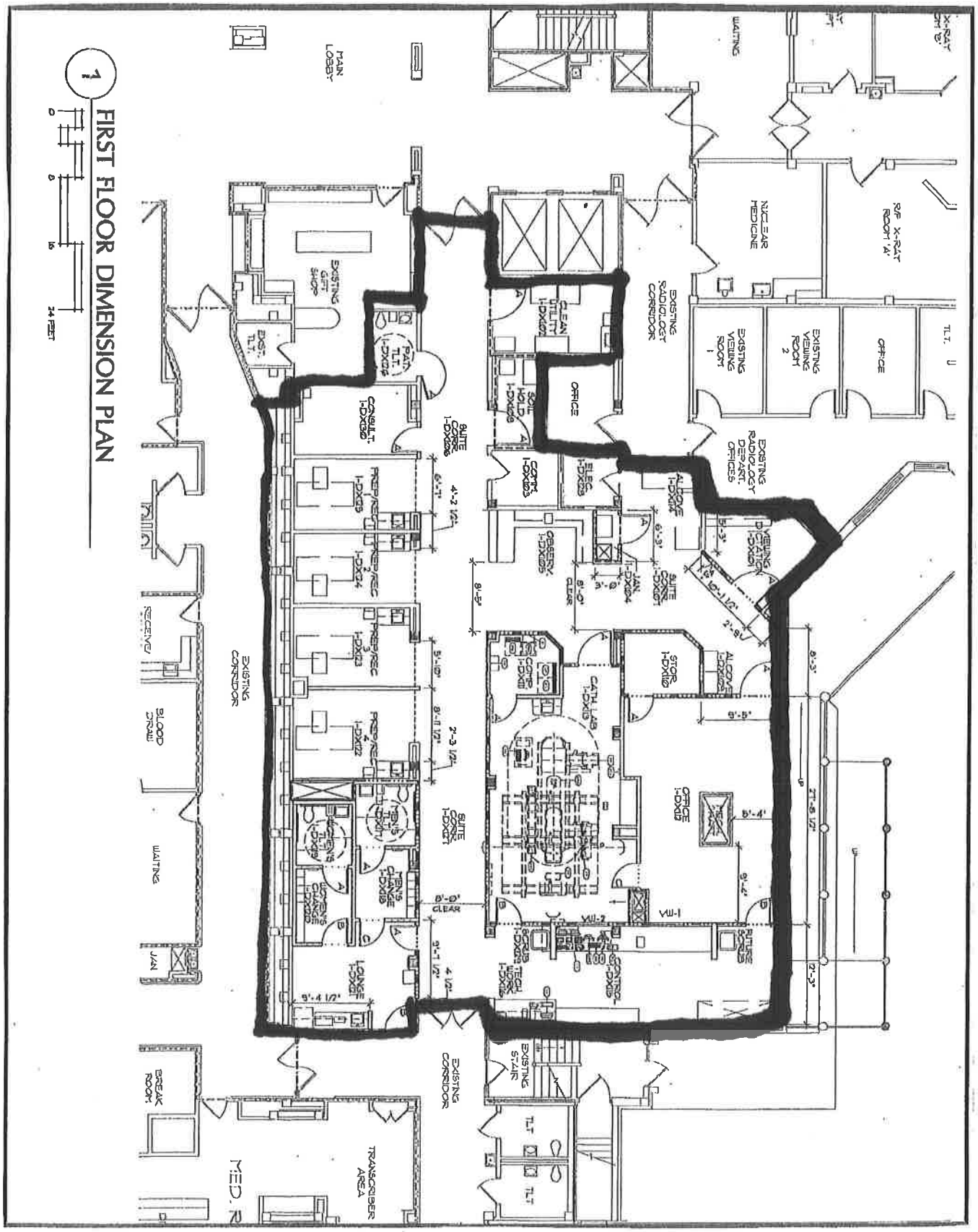
600 ft X 720 ft

= 11.07 Acres



MAR 14'14 AM10:34

Attachment B (III) (A) DRMC Plot Plan



Attachment B (IV) DRMC Cardiac Cath Lab Floor Plan

PATIENT TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") is made as of 4/24/2013, by and between Dyersburg Hospital Corporation doing business as Dyersburg Regional Medical Center and Regional Hospital of Jackson 0180, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of the Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into the Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into the Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by Transferring Facility as requiring the services of Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to Receiving Facility.

2. RESPONSIBILITIES OF TRANSFERRING FACILITY. Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;
(J) Notify Receiving Facility of the estimated time of arrival of the patient;

(K) Provide Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse to consent to treatment or transfer;

(O) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to Receiving Facility; and,

(P) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF RECEIVING FACILITY. Receiving Facility shall be responsible for performing or ensuring performance of the following:
(A) Provide, as promptly as possible, confirmation to Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that Receiving Facility has agreed to accept transfer of the patient. Receiving Facility shall respond to Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at Receiving Facility and provide, on request, the names of on-call physicians to Transferring Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from Transferring Facility who have been accepted by Receiving Facility and a receiving physician, if

deemed necessary by a transferring physician unless such are needed by Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Upon discharge of the patient back to Transferring Facility, provide Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of the patients to Transferring Facility when requested by the patient or Transferring Facility and ordered by the patient's attending/transferring physician, if Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of the Agreement.

(J) Provide Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to the Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER BACK; DISCHARGE; POLICIES. At such time as the patient is ready for transfer back to Transferring Facility or another health care facility or discharge from Receiving

Facility. In accordance with the direction from the responsible physician in Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to Transferring Facility, Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to Transferring Facility. In the event the "transferring facility" transfers a resident with a documented chronic antibiotic resistant infection to the "hospital," the "transferring facility" agrees to re-accept this resident upon discharge from the acute "hospital" provided all other transfer and admission criteria is met. Any return transfer must meet acute care admission criteria and be approved by Receiving Facility's case management nurse.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of the Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts not less than One Million ($1,000,000.00) per occurrence and Three Million ($3,000,000.00) in the aggregate, and shall provide evidence of such coverage upon request.

8. TERM; TERMINATION. The term of the Agreement shall be 12 months, commencing on the 6/1/2013, and ending on 5/31/2014, unless sooner terminated as provided herein. Either party may terminate the Agreement without cause upon 90 days advance written notice to the other party. Either party may terminate the Agreement upon breach by the other party of any material provision of the Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. The Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. The Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. The Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. The Agreement shall be construed in accordance with the laws of the state in which Transferring Facility is located.

11. PARTIAL INVALIDITY. If any provision of the Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or effect the remaining provisions of the Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to Dyersburg Hospital Corporation
d/b/a Dyersburg Regional Medical Center
400 E. Tickle Street Dyersburg, TN 38024
Attn: Chief Executive Officer

If to Regional Hospital of Jackson
367 Hospital Blvd.
Jackson, TN 38305
Attention: Chief Executive Officer

With copy to: Legal Department
4000 Meridian Blvd.
Franklin, TN 37067

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, the Agreement or any of Facilities' rights, duties or obligations under the Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. The Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of the Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payor, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while the Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under the Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend the Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If the Agreement is not so amended in writing within three (3) days after said notice was given, the Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. EXECUTION OF AGREEMENT. The Agreement shall not become effective or in force until all of the below named parties have fully executed the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Agreement as of the day and year written above.

Dyersburg Hospital Corporation
d/b/a:Dyersburg Regional Medical Center
By: _____
Title: Chief Executive Officer
Date: 5/6/13

Regional Hospital of Jackson
By: _____
Title: Hospital CEO
Date: 5/6/13

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement") is made and entered into as of the later of April 10, 2013, or the execution of the Agreement by both parties (the "Effective Date") between AMISUB (SFH), Inc. a Tennessee corporation doing business as Saint Francis Hospital ("Hospital") and Community Health Systems doing business as Dyersburg Regional Medical Center, and are sometimes individually referred to herein as "facility" and collectively as "facilities."

RECITALS:

A. The parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities located in the State of Tennessee ("State").

B. The parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by that facility ("Transferring Facility") as requiring the services of the other facility ("Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission ("Joint Commission") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unlawful discrimination. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. RESPONSIBILITIES OF THE TRANSFERRING FACILITY. The Transferring Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer.

b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations.

c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility.

d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient.

e. Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care.

f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient.

g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician.

h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and, with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible.

i. Transfer the patient's personal effects, including, without limitation, money and valuables, and information related to those items.

j. Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, public hospital, or hospital district.

k. Notify the Receiving Facility of the estimated time of arrival of the patient.

l. Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer.

m. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider.

n. Recognize the right of a patient to request to transfer into the care of a physician and hospital of the patient's choosing.

o. Recognize the right of a patient to refuse consent to treatment or transfer.

p. Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred.

q. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility.

3. **RESPONSIBILITIES OF THE RECEIVING FACILITY.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within thirty (30) minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency.

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility.

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician.

f. Provide the Transferring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the patient is returned to the Transferring Facility by the Receiving Facility.

g. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) for the

Accountability Act of 1996 ("HIPAA"), as well as with all standards promulgated by any relevant accrediting agency.

7. **RESPONSIBILITY; INSURANCE.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **TERM.** The term of this Agreement ("Term"), shall be two (2) year(s) commencing on the Effective Date. At the end of the Term and any Term Extension (as defined herein), the Term shall be automatically extended for additional terms of one (1) year each (a "Term Extension"), unless either party provides the other with written notice of termination as provided herein. As used herein, "Term" shall mean the period of time beginning on the Effective Date and ending on the last day of either the Term or the last Term Extension, as applicable.

9. **TERMINATION.** Either party may terminate this Agreement without cause upon 30 days' written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events: (i) either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately; (ii) either facility loses its license, is convicted of a criminal offense related to health care, or is listed by a federal agency as being debarred, excluded or otherwise ineligible for federal program participation.

10. **ARBITRATION.** Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by final and binding arbitration in the county in which the Hospital is located in accordance with the Commercial Rules of Arbitration ("Rules") of the Judicial Arbitration and Mediation Services ("JAMS") before one arbitrator applying the laws of the State. The parties shall attempt to mutually select the arbitrator. In the event they are unable to mutually agree, the arbitrator shall be selected by the procedures prescribed by the JAMS Rules. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. The provisions set forth herein shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

11. **ENTIRE AGREEMENT; MODIFICATION; GOVERNING LAW, COUNTERPARTS; NOTICES; WAIVER; ASSIGNMENT.** This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement. This Agreement shall be construed in accordance with the laws of the State, which provision shall

survive the expiration or other termination of this Agreement. This Agreement may be executed in one or more counterparts, all of which together shall constitute only one Agreement. All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier, addressed at the place identified on the signature page below. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of the facilities rights, duties or obligations under this Agreement without the prior written consent of Hospital, and any assignment or transfer by any facility without such consent shall be null and void. This Agreement is assignable by Hospital without consent or notice.

12. **REFERRALS.** The parties acknowledge that none of the benefits granted to each other hereunder are conditioned on any requirement that any party make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the other party or its affiliates.

13. **COMPLIANCE OBLIGATIONS.** Delta represents that it read, understands, and shall abide by Tenet's Standards of Conduct. The parties to this Agreement shall comply with Tenet's Compliance Program and Tenet's policies and procedures related to the Deficit Reduction Act of 2005, Anti-Kickback Statute and the Stark Law. Tenet's Standards of Conduct, summary of Compliance Program, and policies and procedures, including a summary of the Federal False Claims Act and applicable state false claims laws (collectively "False Claims Laws") with descriptions of penalties and whistleblower protections pertaining to such laws, are available at: http://www.tenethealth.com/about/pages/ethicscompliance.aspx. Further, each party to this Agreement certifies that it shall not violate the Anti-Kickback Statute and Stark Law, and shall abide by the Deficit Reduction Act of 2005, as applicable, in providing services to the other party. Hardcopies of any information shall be made available upon request.

14. **EXCLUSION LISTS SCREENING.** The facilities shall screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("Screened Persons") against (a) the United States Department of Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov), (b) the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov); and (c) any applicable state healthcare exclusion list (collectively, the "Exclusion Lists") to ensure that none of the Screened Persons are currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs or in Federal procurement or nonprocurement programs, or have been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "Ineligible Person"). If, at any time during the term of this Agreement any Screened Person becomes an Ineligible Person or proposed to be an Ineligible Person, facilities shall immediately notify Hospital of the same. Screened Persons shall not include any employee, contractor or agent who is not providing services under this Agreement.

AMISUB (SFH) INC.
D/B/A SAINT FRANCIS HOSPITAL

By: _____
Name: David L. Archer
Title: President & CEO
Date: 2/18/13
Address: 5959 Park Avenue
Memphis, TN 38119

COMMUNITY HEALTH SYSTEMS
D/B/A DYERSBURG REGIONAL MEDICAL CENTER

By: _____
Name: Ben Hower
Title: CEO
Date: 3/3/13
Address: 400 E. Tickle St.
Dyersburg, TN 38024

PATIENT TRANSFER AGREEMENT
BETWEEN
VANDERBILT UNIVERSITY
AND
DYERSBURG REGIONAL MEDICAL CENTER

In consideration of the needs of the patients of the area served by both the institutions herein named, this Agreement is entered into by and between Vanderbilt University, a Tennessee not-for-profit corporation acting by and through its Vanderbilt University Hospital (hereinafter referred to as "Vanderbilt"), and Dyersburg Regional Medical Center, (hereinafter referred to as "Facility") (both Vanderbilt and Facility will also be referred to collectively as "Institutions" or individually, an "Institution").

WITNESSETH:

WHEREAS, each Institution owns and operates an acute care hospital providing health care services for residents of the area served by such Institution; and,

WHEREAS, both Institutions desire to assure continuity of care and treatment appropriate to the needs of patients and to use the skills and resources of both institutions in a coordinated and cooperative fashion; and

WHEREAS, the parties share a common desire to benefit the communities they serve by assuring the provision of medical care within the communities for those needs that can be met locally and for facilitating access to specialized care when deemed necessary;

WHEREAS, Facility desires to enter to a transfer agreement with Vanderbilt for the continuation of care of certain patients in the event that it is deemed that those Facility patients are in need of the specialized capabilities provided at Vanderbilt

NOW, THEREFORE, in consideration of the promises herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

I. **TERMS AND CONDITIONS:**

A. **Patient Transfer from Facility to Vanderbilt.**

1. Vanderbilt will provide treatment and hospitalization, when and if Vanderbilt has sufficient capacity and capabilities as required by law, for patients of Facility on an as-needed basis when requested by Facility. Facility will refer patients to Vanderbilt only when the patients need treatment, care or tests that are not available at Facility and are available at Vanderbilt.

2. For patients being transferred to Vanderbilt for treatment associated with (burns, trauma) Facility will also adhere to the specific criteria listed in Appendix I, attached hereto and made a part hereof by this reference.

B. **Patient Transfer to Vanderbilt from Facility.**

1. When a patient has been transferred to Vanderbilt from Facility and is admitted and stabilized, but no longer requires specialized services or treatment only available at Vanderbilt, Facility agrees to accept the transfer of, and to readmit, the patient for further required hospitalization within 24-48 hours of such determination. In the event Facility referring physician does not accept the patient, the Facility's Chief of Medical Staff or other authorized representative shall facilitate identification of an appropriate accepting physician for the transfer. Only patients who are appropriate for transfer and who consent shall be transferred to Facility.

C. **Mutual Obligations.**

1. A patient may only be admitted at a receiving Institution after an attending physician at the receiving Institution accepts the patient's admission after speaking with a transferring Institution physician. If the receiving Institution's attending physician has approved and agreed to the admission of the transfer patient (i) after concluding that all conditions of eligibility are met; (ii) subject to availability of appropriate personnel, space and facilities at the receiving Institution: and (iii) to the extent permitted by law if financial arrangements have been made, then the receiving Institution agrees to facilitate prompt admission of the patient. The parties hereto agree to conduct any patient transfers in compliance with state and federal law, including 42 U.S.C. § 1395dd et seq. and any amendments thereto ("EMTALA regulations") and, as applicable, all requirements set forth in 42 C.F.R. § 483 regarding discharge, transfer, and re-admission of nursing home patients, and such other requirements as may be imposed by the Secretary of Health and Human Services and federal or state law.

2. The transferring Institution shall provide, or arrange for the provision of, transportation for a patient for the purpose of his or her transfer to and from the receiving Institution under this Agreement. The appropriate method of transportation is dependent upon patient's condition and such transportation (ground, fixed wing or rotary wing) will be determined after consultation between the transferring and receiving physicians.

3. If the admitting physician or transferring physician should deem it medically necessary for the patient to be accompanied by personnel and/or equipment during the transfer, the transferring Institution shall provide or arrange for, at its cost and expense, the appropriate personnel and/or equipment for the transfer.

4. The transferring Institution agrees to send with each patient at the time of transfer, or, in case of emergency, as promptly as possible after the transfer, pertinent medical and other information necessary to continue the patient's treatment without interruption, together with essential identifying and administrative information.

5. The receiving Institution shall assume responsibility for patient care at the time it takes physical custody of the patient and shall remain responsible for patient care only during the time that the receiving Institution has such physical custody of the patient.

II. BILLING AND PAYMENT

A. It is agreed that the services rendered by the receiving Institution or the receiving Institution's physicians shall be charged to the patient, the patient's Managed Care Organization ("MCO"), or other third party payor. The transferring Institution shall not be held responsible for payment of services rendered to a patient by the receiving Institution or the receiving Institution's physicians and the receiving Institution and the receiving Institution's physicians shall not be held responsible for payment of services rendered to a patient by the transferring Institution.

B. The transferring Institution will provide the receiving Institution with all information necessary to enable the receiving Institution to bill the patient, his or her MCO, or other third party payor for all patient care services rendered by the receiving Institution prior to patient's transfer.

III. TERM AND TERMINATION

A. This Agreement shall be effective from April 1, 2013 and continue until amended, modified, or terminated. This Agreement shall be reviewed on a periodic basis and at that time, both parties will evaluate the program and policies, discuss any related problems, and make necessary revisions. Neither party shall be bound by this Agreement until it is signed by the appropriate officials as indicated on the signature page of this Agreement.

B. Notwithstanding any other terms and conditions hereunder, this Agreement may be terminated without cause by either party by written notification to the other party at least thirty (30) days prior to the desired effective date of termination.

C. In the event that either party shall become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceedings under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of rights of creditors, then, at the option of either party, this Agreement may be terminated immediately by either party and be of no further force and effect.

D. In the event that either party sells all or substantially all of its assets, there is a sale of a majority ownership of either party, or there occurs a material change in the management or ownership of either party, this Agreement may be terminated by either party and be of no further force and effect.

E. Each party warrants that it is duly licensed under the laws of its state and agrees to abide by applicable state and/or federal laws and regulations governing the licensure and operation of its facility. Each party further agrees to give prompt notice in writing to the other party in the event of institution of proceedings for suspension or revocation of its license, and to notify the other party in the event of any suspension or revocation of its license within twenty-four (24) hours of its occurrence. This Agreement will immediately terminate upon the revocation or suspension of licensure of either party. Further, either party, at its sole discretion, may terminate this Agreement in the event the other party is given notice of the institution of proceedings to suspend or revoke its licensure.

IV. INDEMNIFICATION

Each party shall indemnify and hold harmless the other party, its trustees, officers, agents and employees, from any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceeding to the extent arising out of its own negligent acts or omissions in the performance of this Agreement. Indemnitor's obligations as set forth in the preceding sentence are conditioned upon (i) Indemnitee promptly notifying Indemnitor of any claim, demand or action, or any incident of which Indemnitee has actual or constructive knowledge, which may reasonably result in a claim, demand or action, and for which Indemnitee will look to Indemnitor for indemnification under this Section, (ii) Indemnitee, its directors, officers, agents, and employees, cooperating fully with Indemnitor in Indemnitor's investigation and review of any such claim, action or incident, and (iii) Indemnitee not entering into any admissions, agreements or settlements which may affect the rights of Indemnitee or Indemnitor without the prior written consent and approval of Indemnitor. Indemnitor reserves the right, in its sole discretion, to assume the defense of Indemnitee in any such claim, action or proceeding.

V. INSURANCE

A. Each party shall procure and maintain for the term of this Agreement comprehensive general liability insurance, including broad form contractual, in a minimum amount of $1,000,000/$3,000,000. Such coverage shall act as primary insurance and no coverage of the other party shall be called upon to contribute to a loss.

B. Each party shall procure and maintain for the term of this Agreement professional liability insurance, in a minimum amount of $1,000,000/$3,000,000 in coverage for all of its personnel who may participate in this Agreement. Such coverage shall be for a minimum of five (5) years following expiration or termination of this Agreement and shall provide for a retroactive date no later than the inception date of this Agreement

C. Each party shall procure and maintain during the term of this Agreement, workers' compensation and employer liability insurance or a self-insurance program covering all of its employees who are engaged in any work under this Agreement

D. The parties shall provide each other with Certificates of Insurance evidencing the above coverage.

E. It is agreed that Vanderbilt may chose to provide the coverage stated above through a Program of self insurance

VI. NOTIFICATION OF CLAIMS

The parties agree to notify each other as soon as possible in writing of any incident, occurrence, or claim arising out of or in connection with this Agreement which could result in a liability or claim of liability to the other party. Further, the notified party shall have the right to investigate said incident or occurrence and the notifying party will cooperate fully in this investigation

VII. NOTICES

All notices or other communication provided for in this Agreement shall be given to the parties addressed as follows:

FACILITY: Dyersburg Regional Medical Center
400 E. Tickle Street
Dyersburg, TN 38024

VANDERBILT: Larry D. Prisco, Jr.
Director, Social Services
A-1202 Medical Center North
Vanderbilt University Medical Center
Nashville, TN 37232-2415

with a copy to: Office of Grants & Contracts Management
Vanderbilt University Medical Center
3319 West End Avenue, Suite 100
Nashville, TN 37203-6869

VIII. MEDIA

The parties agree they will not use each other party's name or programs in any advertising, promotional material, press release, publication, public announcement, or through other media, written or oral, whether to the press, to holders of publicly owned stock without the prior written consent of the party whose name is to be used

IX. DISCRIMINATION

In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967 and the Americans with Disabilities Act of 1990, each party hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of its policies, including admissions policies, employment, programs or activities

X. ASSIGNMENT AND BINDING EFFECT

Neither party shall assign, subcontract, or transfer any of its rights or obligations under this Agreement to a third party without the prior written consent of the other party. If an assignment, subcontract, or transfer of rights does occur in accordance with this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns

XI. INDEPENDENT CONTRACTOR

Each party shall be considered to be an independent party and shall not be construed to be an agent or representative of the other party, and therefore, has no liability for the acts or omissions of the other party. In addition, neither party, nor any of its employees, agents, or subcontractors, shall be deemed to be employees or agents of the other party. Therefore, neither party nor any of its employees, agents or subcontractors, shall be entitled to compensation, workers compensation, or employee benefits of the other party by virtue of this Agreement.

XII. COUNTERPART SIGNATURE

This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each counterpart shall be deemed an original and all of which shall constitute but one Agreement.

XIII. WRITTEN AMENDMENT/WAIVERS

This Agreement cannot be amended, modified, supplemented or rescinded except in writing signed by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto

XIV. GOVERNING LAW AND JURISDICTION

This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee. Each party hereby consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, agrees that venue for any such action shall lie exclusively in such courts, and agrees that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto.

XV. MEDICAL RECORDS

All medical records and case histories of patients treated by VUMC shall be kept at VUMC, and shall be the property of VUMC. Facility will be provided access to such medical records only with prior written consent of the patient and subject to Vanderbilt policies. Likewise, Vanderbilt will be provided access to such medical records only with prior written consent of the patient and subject to Facility policies.

XVI. ACCESS TO BOOKS AND RECORDS

Until the expiration of four years after the furnishing of services pursuant to this Agreement, the parties shall upon written request, make available to the Secretary of Health and Human Services or the Comptroller General or their duly authorized representative the contract, books, documents, and records necessary to verify the nature and extent of the cost of such services. If either party carries out any of its obligations under this Agreement by means of a subcontract with a value of $10,000 or more, that party agrees to include this requirement in any such subcontract

XVII. CONSTRUCTION OF AGREEMENT

The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement. This Agreement has been prepared on the basis of mutual understanding of the parties and shall not be construed against either party by reason of such party's being the drafter hereof.

XVIII. NON-EXCLUSIVITY

Each party shall have the right to enter into similar agreements with other parties.

XIX. CONFIDENTIALITY

The parties agree to maintain as private and confidential all information which relates to or identifies a particular patient, including but not limited to the name, address, medical treatment or condition, financial status, or any other personal information which is deemed to be confidential in accordance with applicable state and federal law and standards of professional ethics and will train their employees, contractors, subcontractors, agents, and representatives to comply with such confidentiality requirements.

XX. HIPAA REQUIREMENTS

The parties acknowledge that each party is a "covered entity" as that term is defined at 45 C.F.R. Part 160.103. As such, the parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA") and any current and future regulations promulgated thereunder including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements". The parties agree not to use or further disclose any Protected Health Information, other than as permitted by HIPAA Requirements and the terms of this Agreement. The parties will respectively make their internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

XXI. COMPLIANCE WITH PATIENT TRANSFER REQUIREMENTS

All parties hereto agree that any patient transfers shall be in compliance with the EMTALA Regulations, and such other requirements as may be imposed by the Secretary of Health and Human Services, and any other applicable State patient transfer laws.

XXII. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

SIGNATURE PAGE FOR GENERAL PATIENT TRANSFER AGREEMENTS

IN WITNESS WHEREOF the parties hereto have caused this Agreement to be executed by their duly authorized representatives on the last signature date specified below.

FOR VANDERBILT UNIVERSITY
Recommended By:

Larry D. Cuisco, Jr.
Director, Social Services
Vanderbilt University Hospital

Date 05/03/13

Pam Jones
Associate Hospital Director
Vanderbilt University Hospital

Date 05/10/13

Mitchell C. Edgeworth
Chief Operating Officer
Vanderbilt University Hospital

Date 5.10.13

Approved By:

C. Wright Pinson, M.B.A., M.D.
Deputy Vice Chancellor for Health Affairs
Senior Associate Dean for Clinical Affairs
CEO of the Vanderbilt Health System

Date 5/16/13

FOR FACILITY

Ben Youree, CEO
Dyersburg Regional Medical Center

Date 4/17/13

REF:C:\DOCUME~1\JOHNSTMB\LOCALS~1\TEMP\WETASAVE\RT-#3015024-V4-VANDERBILT_TRANSFER_AGREEMENT.DOC as of April 17, 2013.

Reviewed for Signature
Contracts Mgmt
Contract Analyst

APPENDIX I

Transfers will be evaluated upon the following medical criteria:

A. Transfer of a burn patient may be requested by the FACILITY when the extent of the burn patient's injuries or the number of burn patients exceed FACILITY'S capabilities in accordance with the following:

1. Full thickness burn exceeding 10% TBSA.
2. Partial thickness burn exceeding 20% TBSA.
3. Serious burns of hands, face, feet, genitalia, or perineal region.
4. Inhalation injury with respiratory compromise.
5. High voltage electrical burns.
6. Chemical burns.
7. Burns associated with extremes of age or serious pre-existing medical illnesses.
8. Pediatric patients with a burn injury. If patient is intubated, patient will be transferred to Pediatric Intensive Care Unit after being accepted by Pediatric Intensive Care Unit attending service.

B. FACILITY shall be responsible for preparation of patient for transfer including performing the following therapeutic interventions as ordered by the transferring physician prior to the transfer:

1. Establishment and maintenance of a secure airway and satisfactory ventilation with continuous monitoring during transport.
2. Resuscitation and Early Care may include:
   a. Establishment of large bore intravenous catheters.
   b. Fluid resuscitation with Lactated Ringer's to maintain a urine output greater than 2cc/Kg/hr for patient weighing less than 60 kilograms or 30cc's for an adult.
   c. Calculation and estimation of fluid needs with the following formula: (2-4cc's) multiplied by %TBSA burn multiplied by patient weight in kilograms for the first 24 hours.
   d. Half of the calculated fluid to be given with the first eight hours post burn, the second half to be given over the next 16 hours.
   e. Insertion of a Foley catheter.
   f. Insertion of a nasogastric tube.
   g. Administration of small amounts of intravenous narcotics as needed for pain.
   h. Adequate lavage and irrigation of chemical burns.
   i. Ongoing examination of peripheral pulses in circumferentially burned extremities.
   j. Escharotomy is to be considered in the presence of circumferential burns when vascular compromise is evident. In the absence of a trained surgeon, the referral facility should communicate with the burn fellow or attending physician prior to performing an escharotomy.
   k. Burn wounds are to be managed by wrapping in clean, dry sheets.

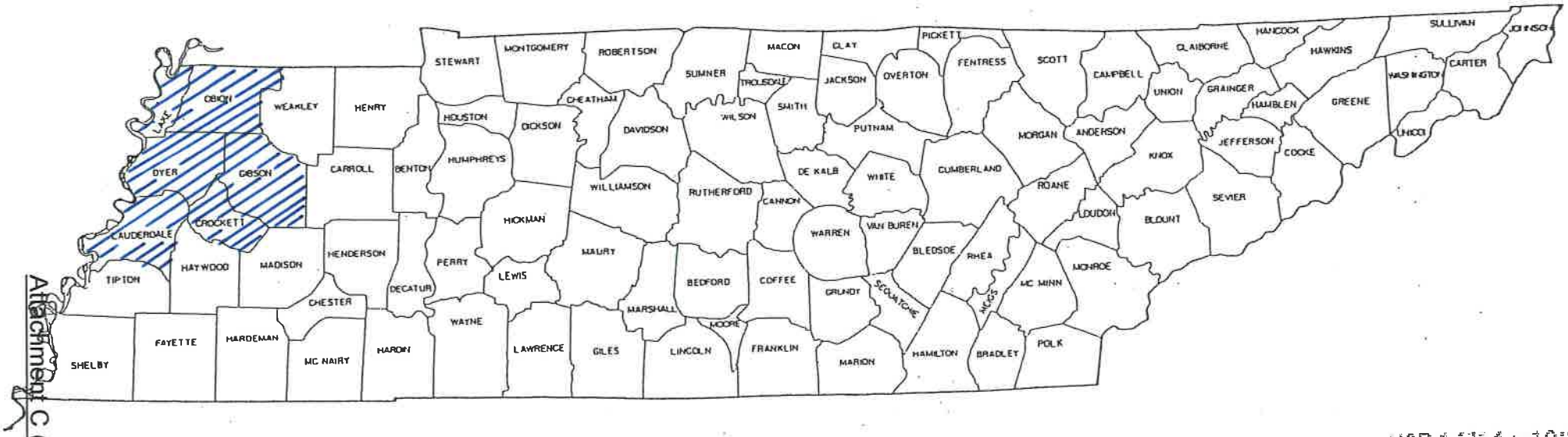
C. Patients will not routinely receive antibiotics prior to transfer, but tetanus immunization status will be ascertained by patient's attending physician, and prophylaxis administered and documented by transferring facility.

D. Every effort will be made to transport burn patients as soon as possible. However, patients who are hemodynamically unstable may require a period of up to 48 hours of stabilization.

PROPOSED SERVICE AREA

INTERVENTIONAL CATH FOR

DYERSBURG REGIONAL MEDICAL CENTER



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Attachment C (III) Proposed Service Area Map

Dyersburg Regional
MEDICAL CENTER

400 Tickle Street • Dyersburg, TN 38024

March 4, 2014

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Re: Dyersburg Regional Medical Center

Dear Ms. Hill:

I am Chief Financial Officer for Dyersburg Regional Medical Center ("DRMC"). DRMC has filed a certificate of need application for authorization to perform interventional cardiac catheterization procedures in its existing cardiac cath lab. The estimated project cost is $364,763.00. Dyersburg Hospital Corporation, the owner of DRMC, will fund these project costs out of cash reserves, which are currently available for this purpose.

Please let me know if you have any questions or if additional information is needed. Thank you for your assistance.

Sincerely,

Meredith Malone

Meredith Malone, CFO

GL0R15

DYERSBURG RMC - DYERSBURG, TN 0180

INCOME STATEMENT D-57

FOR THE PERIOD ENDING FEBRUARY 28, 2014

DATE: 3/12/14
TIME: 18:27:35

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
TOTAL PATIENT DAYS BY PA	1264	1048											2312
AVERAGE DAILY CENSUS	40.8	37.4	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	39.2
Patient Revenue:													
Inpatient Routine	2,147,357	1,840,772	0	0	0	0	0	0	0	0	0	0	3,988,129
Inpatient Ancillary	15,624,416	12,082,269	0	0	0	0	0	0	0	0	0	0	27,706,685
Outpatient	28,071,743	27,335,554	0	0	0	0	0	0	0	0	0	0	55,407,297
Total Patient Revenue	45,843,516	41,258,595	0	0	0	0	0	0	0	0	0	0	87,102,111
Deductions From Revenue:													
I/P - M/M Contractual	11,410,513	8,646,078	0	0	0	0	0	0	0	0	0	0	20,056,591
O/P - M/M Contractual	14,740,408	14,250,760	0	0	0	0	0	0	0	0	0	0	28,991,168
Other Contractual Adj.	12,971,671	12,867,669	0	0	0	0	0	0	0	0	0	0	25,839,340
Courtesy Discounts	367	5,559	0	0	0	0	0	0	0	0	0	0	5,926
Total Deductions From Re	39,122,959	35,770,066	0	0	0	0	0	0	0	0	0	0	74,893,025
Net Pt Rev Before Bad Db	6,720,557	5,488,529	0	0	0	0	0	0	0	0	0	0	12,209,086
Provision for Bad Dbt	1,102,651	631,897	0	0	0	0	0	0	0	0	0	0	1,734,548
Net Pt Rev After Bad Dbt	5,617,906	4,856,632	0	0	0	0	0	0	0	0	0	0	10,474,538
Other Revenue	22,949	24,958	0	0	0	0	0	0	0	0	0	0	47,907
Net Revenue	5,640,855	4,881,590	0	0	0	0	0	0	0	0	0	0	10,522,445
Operating Expenses:													
Salaries & Wages	1,564,198	1,424,948	0	0	0	0	0	0	0	0	0	0	2,989,146
Benefits	515,220	488,386	0	0	0	0	0	0	0	0	0	0	1,003,606
Contract Labor	21,192	12,100	0	0	0	0	0	0	0	0	0	0	33,292
Supplies	571,075	582,926	0	0	0	0	0	0	0	0	0	0	1,154,001
Medical Spec Fees	241,202	130,744	0	0	0	0	0	0	0	0	0	0	371,946
Purchased Services	422,570	460,079	0	0	0	0	0	0	0	0	0	0	882,649
Physician Recruiting	18,187	4,483	0	0	0	0	0	0	0	0	0	0	22,670
Repairs & Maintenance	186,626	116,191	0	0	0	0	0	0	0	0	0	0	302,817
Marketing	23,700	7,123	0	0	0	0	0	0	0	0	0	0	30,823
Utilities	95,255	100,564	0	0	0	0	0	0	0	0	0	0	195,819
Other Operating Exp	82,740	82,350	0	0	0	0	0	0	0	0	0	0	165,090
Prop Taxes & Ins	517,531	489,371	0	0	0	0	0	0	0	0	0	0	1,006,902
HITECH Incentives	(1,228,352)	0	0	0	0	0	0	0	0	0	0	0	(1,228,352)
Total Operating Expenses	3,031,144	3,899,265	0	0	0	0	0	0	0	0	0	0	6,930,409
Operating Margin	2,609,711	982,325	0	0	0	0	0	0	0	0	0	0	3,592,036
Rent	112,005	126,588	0	0	0	0	0	0	0	0	0	0	238,593
E.B.I.T.D.A.	2,497,706	855,737	0	0	0	0	0	0	0	0	0	0	3,353,443
Depreciation and Amortiz	298,260	297,596	0	0	0	0	0	0	0	0	0	0	595,856
E.B.I.T.	2,199,446	558,141	0	0	0	0	0	0	0	0	0	0	2,757,587
Interest	213,654	317,822	0	0	0	0	0	0	0	0	0	0	531,476
Pre-Tax Profit	1,985,792	240,319	0	0	0	0	0	0	0	0	0	0	2,226,111
Corp Mgmt Fees	236,421	236,421	0	0	0	0	0	0	0	0	0	0	472,842
TOTAL SURGERIES	676	700											1376
TOTAL ADMISSIONS	393	330											723
TOTAL DELIVERIES	41	38											79
TOTAL O/P REGS INCL ALL	6147	2929											9076
TOTAL E.R. VISITS	2127	1899											4026
Total Paid Hours	61890	55766											117656
Total Paid & Contract Ho	61890	55766											117656
TOTAL PAID & CONTRACT FT	349.66	348.53	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00	349.13

Attachment C, 10 Financial Statements

GL0R15

DYERSBURG RMC - DYERSBURG, TN 0180

INCOME STATEMENT D-57

FOR THE PERIOD ENDING DECEMBER 31, 2013

DATE: 3/12/14
TIME: 18:27:26

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
TOTAL PATIENT DAYS BY PA	1171	1019	980	904	922	738	852	942	1026	835	819	927	11135
AVERAGE DAILY CENSUS	37.8	36.4	31.6	30.1	29.7	24.6	27.5	30.4	34.2	26.9	27.3	29.9	30.5
Patient Revenue:													
Inpatient Routine	1,791,219	1,591,403	1,472,391	1,466,988	1,515,152	1,287,552	1,440,613	1,651,335	1,763,923	1,426,650	1,434,140	1,678,291	18,519,657
Inpatient Ancillary	13,522,976	12,002,240	10,483,720	11,289,782	10,921,468	9,338,850	11,154,836	11,531,605	12,195,374	10,355,995	10,294,985	10,636,187	133,728,018
Outpatient	24,530,975	22,383,410	24,662,081	25,910,513	24,410,932	25,387,509	24,141,360	26,871,496	23,605,451	27,251,352	22,961,999	23,943,781	296,060,859
Total Patient Revenue	39,845,170	35,977,053	36,618,192	38,667,283	36,847,552	36,013,911	36,736,809	40,054,436	37,564,748	39,033,997	34,691,124	36,258,259	448,308,534
Deductions From Revenue:													
I/P - M/M Contractual	9,196,962	9,234,316	7,652,662	7,573,770	7,785,226	6,691,870	7,968,095	7,908,775	8,604,824	7,710,837	6,961,329	7,903,158	95,191,824
O/P - M/M Contractual	13,235,855	11,611,770	13,729,715	13,161,182	12,797,681	13,442,997	13,030,411	14,656,194	12,837,141	14,925,885	12,302,075	12,180,873	157,911,779
Other Contractual Adj.	10,883,493	9,493,786	9,249,084	11,746,936	10,581,538	9,992,630	10,913,825	12,241,964	10,285,033	10,731,645	9,842,122	10,013,301	125,975,357
Courtesy Discounts	4,254	4,358	13,885	2,412	5,117	3,090	5,251	7,133	(38,139)	10,829	3,986	5,234	27,410
Total Deductions From Re	33,320,564	30,344,230	30,645,346	32,484,300	31,169,562	30,130,587	31,917,582	34,814,066	31,688,859	33,379,196	29,109,512	30,102,566	379,106,370
Net Pt Rev Before Bad Db	6,524,606	5,632,823	5,972,846	6,182,983	5,677,990	5,883,324	4,819,227	5,240,370	5,875,889	5,654,801	5,581,612	6,155,693	69,202,164
Provision for Bad Dbt	935,549	883,760	1,285,769	697,475	924,351	620,422	995,838	760,165	956,355	810,179	953,249	1,089,204	10,912,316
Net Pt Rev After Bad Dbt	5,589,057	4,749,063	4,687,077	5,485,508	4,753,639	5,262,902	3,823,389	4,480,205	4,919,534	4,844,622	4,628,363	5,066,489	58,289,848
Other Revenue	29,357	30,307	20,098	32,097	28,636	30,670	24,362	26,073	52,005	28,591	26,073	23,368	351,637
Net Revenue	5,618,414	4,779,370	4,707,175	5,517,605	4,782,275	5,293,572	3,847,751	4,506,278	4,971,539	4,873,213	4,654,436	5,089,857	58,641,485
Operating Expenses:													
Salaries & Wages	1,559,347	1,404,800	1,395,317	1,468,315	1,489,075	1,354,916	1,401,005	1,445,157	1,425,359	1,429,530	1,448,029	1,513,526	17,334,376
Benefits	539,270	527,792	524,789	499,273	512,631	418,267	468,842	477,834	452,130	456,597	408,303	227,027	5,512,755
Contract Labor	0	0	0	0	0	0	0	0	0	18,093	30,263	38,709	87,065
Supplies	685,917	547,412	492,789	598,576	598,920	536,589	376,221	517,198	494,938	504,742	481,733	505,658	6,340,693
Medical Spec Fees	232,351	116,718	126,463	182,862	91,181	174,156	141,709	226,532	280,827	204,110	182,921	171,123	2,130,953
Purchased Services	371,113	425,974	438,988	462,907	447,602	443,819	491,123	427,329	440,116	453,376	410,957	392,152	5,205,456
Physician Recruiting	16,441	1,400	5,250	7,495	2,500	30	117	4,642	(1,513)	1,930	17,154	4,100	59,546
Repairs & Maintenance	115,278	129,261	110,738	131,370	109,423	134,292	93,524	116,313	101,967	142,993	68,860	115,952	1,369,971
Marketing	12,138	10,961	7,885	9,611	4,879	5,727	15,629	5,940	10,675	14,657	3,550	9,275	110,927
Utilities	111,584	69,794	80,267	97,446	92,694	96,119	96,876	96,491	95,304	90,770	85,318	88,470	1,101,133
Other Operating Exp	78,360	75,437	46,810	78,746	46,772	56,538	66,810	49,055	58,826	55,603	62,960	52,517	728,434
Prop Taxes & Ins	488,625	477,604	474,902	497,222	488,186	476,999	493,655	483,182	473,481	493,612	475,102	103,342	5,425,912
HITECH Incentives	(1,720,253)	0	0	0	0	96,832	0	0	(389,724)	(4,730)	0	0	(2,017,875)
Total Operating Expenses	2,490,171	3,787,153	3,704,198	4,033,823	3,883,863	3,794,284	3,645,511	3,849,673	3,442,386	3,861,283	3,675,150	3,221,851	43,389,346
Operating Margin	3,128,243	992,217	1,002,977	1,483,782	898,412	1,499,288	202,240	656,605	1,529,153	1,011,930	979,286	1,868,006	15,252,139
Rent	112,715	114,548	126,087	125,826	113,739	124,228	124,622	97,336	113,963	111,650	126,377	120,405	1,411,496
E.B.I.T.D.A.	3,015,528	877,669	876,890	1,357,956	784,673	1,375,060	77,618	559,269	1,415,190	900,280	852,909	1,747,601	13,840,643
Depreciation and Amortiz	435,526	439,422	(21,116)	291,830	288,161	286,172	276,272	357,099	328,247	344,062	252,031	295,776	3,573,482
E.B.I.T.	2,580,002	438,247	898,006	1,066,126	496,512	1,088,888	(198,654)	202,170	1,086,943	556,218	600,878	1,451,825	10,267,161
Interest	328,932	323,496	337,879	332,892	350,646	346,071	348,319	347,735	343,262	360,696	357,525	371,487	4,148,940
Pre-Tax Profit	2,251,070	114,751	560,127	733,234	145,866	742,817	(546,973)	(145,565)	743,681	195,522	243,353	1,080,338	6,118,221
Corp Mgmt Fees	217,573	217,573	217,573	217,573	217,573	217,573	217,573	217,573	217,573	217,573	217,573	(114,727)	2,278,576
TOTAL SURGERIES	726	713	758	832	645	721	619	762	695	786	642	553	8452
TOTAL ADMISSIONS	367	330	301	311	323	267	319	329	317	271	292	320	3747
TOTAL DELIVERIES	32	39	26	35	32	40	42	47	41	38	54	35	461
TOTAL O/P REGS INCL ALL	5254	4655	5161	5191	6247	5495	6060	5073	5204	5666	4878	5536	64420
TOTAL E.R. VISITS	2283	2009	2165	2111	2299	2150	2225	2214	2084	2116	1938	1971	25565
Total Paid Hours	66396	58573	61573	59430	61661	58317	56853	59267	58000	59637	59932	59857	719496
Total Contract Hours		1											1
Total Paid & Contract Ho	66396	58574	61573	59430	61661	58317	56853	59267	58000	59637	59932	59857	719497
TOTAL PAID & CONTRACT FT	375.12	366.09	347.87	347.54	348.37	341.03	321.21	334.84	339.18	336.93	350.48	338.17	345.41

DYERSBURG RMC - DYERSBURG, TN 0180 DATE: 3/14/14
TIME: 9:23:02

BALANCE SHEET : B-77
AT
DECEMBER 31, 2013

	THIS MONTH	LAST MONTH	INCR/(DECR)
ASSETS			
Current Assets:			
Cash and cash equivalents	$ 613,065	$ 658,654	$ (45,589)
Patient accounts receivable	14,789,207	13,445,749	1,343,458
Less: Allowance for bad debts	(4,481,949)	(4,300,154)	(181,795)
Prior yr cst rpt settlemt a/r	(726,915)	(726,915)	00
Supplies	1,998,674	1,980,325	18,349
Prepaid expenses	344,623	373,328	(28,705)
Other current assets	(1,186,996)	395,847	(1,582,843)
Total Current Assets	11,349,709	11,826,834	(477,125)
Property & Equipment, at cost:			
Land and improvements	2,291,631	2,291,631	00
Buildings and improvements	39,231,282	39,218,819	12,463
Equipment and fixtures	18,176,478	18,086,592	89,886
Construction in progress	00	34,935	(34,935)
	59,699,391	59,631,977	67,414
Less accumulated depreciation and amortization	(35,480,567)	(35,238,552)	(242,015)
Net Property and Equipment	24,218,824	24,393,425	(174,601)
Other Assets:			
Investment in subs	10,000	10,000	00
Physician recruitment costs	290,435	273,935	16,500
Defered MIS charges	1,850,066	1,840,091	9,975
Other deferred charges	60,208	57,896	2,312
Total Other Assets	2,210,709	2,181,922	28,787
Total Assets	$ 37,779,242	$ 38,402,181	$ (622,939)

DYERSBURG RMC - DYERSBURG, TN 0180 DATE: 3/14/14
TIME: 9:23:02

BALANCE SHEET : B-77
AT
DECEMBER 31, 2013

	THIS MONTH	LAST MONTH	INCR/(DECR)
LIABILITIES			
Current Liabilities:			
Current maturities of			
Accounts payable	2,518,969	1,193,142	1,325,827
Accrued liabilities:			
Employee compensation	1,908,270	1,641,408	266,862
Other accrued liabilities	206,562	778,143	(571,581)
Total Current Liabilities	4,633,801	3,612,693	1,021,108
Deferred Credits and			
Intercompany Accounts	(8,973,123)	(6,134,011)	(2,839,112)
Total Liabilities	$ (4,339,322)	$ (2,521,318)	$ (1,818,004)
Stockholders' Equity			
Retained earnings-prior year	38,278,926	38,278,926	00
Retained earnings-curr year	3,839,638	2,644,573	1,195,065
Total Stockholders' Equity	42,118,564	40,923,499	1,195,065
Total Liabilities and Equity	$ 37,779,242	$ 38,402,181	$ (622,939)

Dyersburg Regional Medical Center Health Care Contracts

Ahmad Al-Hamda, MD	On Call Coverage
Apex Cardiology	On Call Coverage
Brook Adams, MD	On Call Coverage
Oakwood Community Living Center	Patient Transfer
Duckworth Pathology Group	Pathology
Duckworth Pathology Group	Pathology
Dyersburg Manor Nursing & Rehab Center	Under Arrangements Skilled Nursing Facility
EmCare Physician Services, Inc.	Surgery
Family Care, PC	Cardiology
G Bradford Wright MD	On Call Coverage
James Naifeh, MD	On Call Coverage
Keith Nord MD	On Call Coverage
The Bridge at Ridgely	Patient Transfer
Memphis Hearing Aid & Audiological	Audiology
Mid South Transplant Foundation, Inc.	Organ Procurement or Harvesting
Monroe Carrell Jr Childrens Hospital at Vanderbilt	Patient Transfer
Reelfoot Manor Nursing Home	Patient Transfer
Regional Hospital of Jackson	Patient Transfer
The Highlands of Dyersburg	Patient Transfer
Timothy D Sweo MD	On Call Coverage
Vanderbilt University Medical Center	Patient Transfer
Virtual Radiological Professionals Of Minnesota PA	Radiology-Imaging
William Matthew Tosh DO	On Call Coverage

Dyersburg Hospital Corporation

Dyersburg, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

May 18, 2013

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD.
Chair, Board of Commissioners

Organization ID #: 4049
Print/Reprint Date: 08/05/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.

Attachment C, (III) (5) The Joint Commission Accreditation

Board for Licensing Health Care Facilities

State of Tennessee

0000000030

No. of Beds 0225

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

DYERSBURG HOSPITAL CORPORATION *to conduct and maintain a*

Hospital DYERSBURG REGIONAL MEDICAL CENTER

Located at 400 TICKLE STREET. DYERSBURG

County of DYER *, Tennessee.*

This license shall expire MAY 18 , 2014 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 18TH *day of* MAY , 2013 .

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC PRIMARY HOSPITAL

By Vincent T. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature]
COMMISSIONER

Attachment C, (III) 7 (c)(1)DRMC Hospital License

The Joint Commission

Dyersburg Hospital Corporation
400 Tickle Street
Dyersburg, TN 38024

Organization Identification Number: 4049

Program(s)	**Survey Date(s)**
Hospital Accreditation	05/14/2013-05/17/2013

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Attachment C, (III) 7 (d) Joint Commission Survey

The Joint Commission
Summary of Findings

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	IC.02.02.01	EP2,EP4
	LS.02.01.20	EP1,EP31

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.05	EP10
	EC.02.06.01	EP1
	LS.02.01.35	EP6
	RC.01.01.01	EP19
	RC.01.04.01	EP4
	RC.02.03.07	EP4
	TS.03.02.01	EP2

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)	A-0450	HAP - RC.02.03.07/EP4	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP1, EP31, LS.02.01.35/EP6	Standard

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CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - IC.02.02.01/EP2, EP4	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.05

Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Communication

Element(s) of Performance:

10. For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The completion dates of the inspections are documented.
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-7.1).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 10
Observed in Document Review at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
The last quarterly testing of all fire department water supply connections was conducted on 2/26/13. The form stated "all connections checked". There were 3 connections, the vendor did not fill out the form which specified the three locations. Without the form being filled out verification of the specific locations was not available.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

Standard Text: The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
In the dock tank storage room there were several E size O2 cylinders that were leaning into the fence. They were at risk of falling over

Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
In the dock tank storage room there were several H size NO2 cylinders that were not properly secured. They were at risk of being knocked over.

Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
In room B121 there were several H size CO2 cylinders. Several tanks had been removed. The chain was not repositioned. The tanks were loose and at risk of being knocked over.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring
Category : A
Score : Insufficient Compliance

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities in Surgery it was observed that routine biological monitoring of immediate use (flash) sterilization cycles was being performed using a biological indicator (BI) placed in an open mesh container. According to staff, this was for the purpose of daily sterilizer efficacy testing. It was further observed that instruments were undergoing immediate use sterilization inside a closed rigid container designed for this purpose. According to AAMI ST79 10.7.4.1, "A representative of the same type of tray to be routinely processed through the flash sterilizer should be selected to serve as the PCD (BI challenge test tray)." Therefore, when performing daily sterilizer efficacy testing, the BI should have been placed inside the closed rigid container as this was the tray configuration used by the Hospital for immediate use sterilization.

Observed in Tracer Activities at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities in Surgery (Sterile Processing) it was observed that a mechanical instrument washer was being used. However, according to staff, the effectiveness of the mechanical instrument washer was not being routinely tested. According to AAMI ST79 7.5.3.3, "Mechanical cleaning equipment should be tested upon installation, weekly (preferably daily) during routine use, and after major repairs." It should also be noted that various instrument washer testing products designed specifically for this purpose were commercially available.

Observed in Tracer Activities at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities in Surgery it was observed that sterilized instruments and medical supplies were frequently being double packaged in paper-plastic pouches (peel packs). It was further observed that in many cases the inner package had been folded to varying degrees in order to accommodate placement into the outer package. However, according to AAMI ST79 8.3.4, "If the item is to be double-packaged, two sequentially sized pouches should be used (i.e., the sealed inner pouch should fit inside the other pouch without folding)."

EP 4
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities in Surgery (preoperative area) it was observed that Magill forceps were being stored in a code cart. It was further observed that the Magill forceps were not being stored inside any type of protective covering or wrapping. By not being stored inside any type of protective covering or wrapping, it was impossible to determine if the Magill forceps had been previously used and inadvertently placed back in the drawer. Furthermore, such storage conditions would have made it difficult to maintain the ongoing cleanliness of the Magill forceps.

Observed in Tracer Activities at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities in Surgery (PACU) it was observed that Magill forceps and a plastic oral airway were being stored inside a code cart. It was further observed that both instruments were not being stored inside any type of protective covering or wrapping. By not being stored inside any type of protective covering or wrapping, it was impossible to determine if the Magill forceps and/or plastic oral airway had been previously used and inadvertently placed back in the drawer. Furthermore, such storage conditions would have made it difficult to maintain the ongoing cleanliness of these instruments.

Observed in Tracer Activities at Riverside Surgery Center, a Dept of Dyersburg Regional M. C. (420 Wilkinson

Drive, Dyersburg, TN) site for the Hospital deemed service.
During tracer activities it was observed that the bottom shelf of an endoscope storage cabinet was wet and dusty. The endoscopes in the cabinet were being stored vertically and their tips were located close to the bottom shelf.

Chapter: Life Safety

Program: Hospital Accreditation

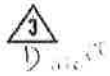
Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)



Scoring
Category : A
Score : Insufficient Compliance

31. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high (or 6 inches high if externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 7.10.1.2, 7.10.5, 7.10.6.1, and 7.10.7.1)

Scoring
Category : C
Score : Partial Compliance

Observation(s):

The Joint Commission
Findings

EP 1
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
There was an illuminated exit sign above the doors leading out of the rear exit in the Cardiac Cat Lab. The door was locked in the direction of egress.This was observed and then corrected at the time of survey.

EP 31
§482.41(b)(1)(i) - (A-0710) - (I) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
There were 4 exits leading out of the cafeteria. The right side exit in the main eating area did not have a lit exit sign above or near the exit door.

Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
There were 4 exits leading out of the cafeteria. The exit leading out of the private dining room did not have a lit exit sign above or near the exit door.

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.35
Standard Text:	The hospital provides and maintains systems for extinguishing fires.
Primary Priority Focus Area:	Physical Environment

Element(s) of Performance:

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
There was not 18 inches or more of open space maintained below the sprinkler deflector to the top of storage in the kitchen dry storage room. This was observed and then corrected at the time of survey.

Observed in Building Tour at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
There was not 18 inches or more of open space maintained below the sprinkler deflector to the top of storage in the Marketing storage room. This was observed and then corrected at the time of survey.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activity and review of the medical record of a patient in the intensive care unit, an order for a T&C had been authenticated but not dated or timed.

Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During closed record review of a pediatric patient, a progress note written on 5/9 had not been timed.

Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During an individual patient tracer it was observed that three physician progress notes were not timed.

Chapter: Record of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: RC.01.04.01
Standard Text: The hospital audits its medical records.
Primary Priority Focus Area: Information Management

Element(s) of Performance:

4. The medical record delinquency rate averaged from the last four quarterly measurements is 50% or less of the average monthly discharge (AMD) rate. Each individual quarterly measurement is no greater than 50% of the AMD rate. (See also MS.05.01.03, EP 3)
Note: To calculate the quarterly and annual average medical record delinquency rate, the Medical Record Statistics Form can be used. This form is available at http://www.jointcommission.org/Hospital_Medical_Record_Statistics_Form/

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

The staff in Medical Records verified that the numbers on the medical records delinquency form showing insufficient compliance were correct

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Chapter: Record of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: RC.02.03.07
Standard Text: Qualified staff receive and record verbal orders.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

4. Verbal orders are authenticated within the time frame specified by law and regulation. 

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activity and review of the medical record of a patient in ICU, telephone orders received on 5/11 at 1125 and 1310 had not been authenticated within the 48 hour timeframe set by medical staff bylaws.

Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During review of a closed medical record of a pediatric patient, telephone orders received on 5/9 at 1045 had not been authenticated within the 48 hour timeframe set by medical staff bylaws.

Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During closed record review of a newborn transfer, telephone orders received on 4/19 at 0110 had not been authenticated within timeframe of 48 hours set by medical staff bylaws.

Observed in Individual Tracer at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site for the Hospital deemed service.
During tracer activity and review of the medical record of a dialysis patient, a verbal order for dialysis treatment was received on 5/12 at 0826 but had not ben authenticated within the timeframe of 48 hours set by medical staff bylaws.

Chapter: Transplant Safety

Program: Hospital Accreditation

Standard: TS.03.02.01

Standard Text: The hospital traces all tissues bi-directionally.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

2. The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues. 

Scoring
Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in Document Review at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
During a review of the implantable tissue log in Surgery, staff stated that they do not routinely document the lot numbers of any solutions used in the preparation of implantable tissue.

Observed in Document Review at Dyersburg Hospital Corporation (400 Tickle Street, Dyersburg, TN) site.
A review of the Hospital policy entitled "Use and Storage of Tissue Grafts and Human Tissue Products" revealed that there was no requirement for documenting the lot numbers of any solutions used in the preparation of implantable tissues.

The Joint Commission

May 31, 2013

Ben Youree, MBA/MHA
Chief Executive Officer
Dyersburg Hospital Corporation
400 Tickle Street
Dyersburg, TN 38024

Joint Commission ID #: 4049
Program: Hospital Accreditation
Accreditation Activity: Unannounced Full Event
Accreditation Activity Completed: 05/17/2013

Dear Mr. Youree:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

May 31, 2013

Ben Youree
Chief Executive Officer
Dyersburg Hospital Corporation
400 Tickle Street
Dyersburg, Tennessee 38024

HCO ID: #4049

Dear Mr. Youree:

We appreciate your patience while we reviewed your clarification request regarding the findings of the May 14-17, 2013 full resurvey of your hospital program. Our review is now complete. Careful consideration was given to the original survey findings and the documentation submitted by your organization. Based on our review, below you will find information specific to the clarification submitted and the impact on your organization's final report.

- LS.02.01.35, EP 6 -- The clarification submitted at this standard/ep was accepted. The documentation submitted for review, as well as the audit data, contained sufficient evidence to demonstrate that your organization was over 90% compliant with the requirements of this EP at the time of your survey. As a result, LS.02.01.35 is no longer listed as a Requirement for Improvement on your official accreditation report.

Please feel free to contact me at 630-792-5737 with any questions.

Sincerely,

Kelli Jacobs

Kelli Jacobs
Sr. Account Executive
Accreditation and Certification Operations

cc: Paul Ziaya, Field Director, The Joint Commission
Martin Feldman, MD, Field Representative, The Joint Commission
Jane Burdick, Field Representative, The Joint Commission
David Sladewski, Field Representative, The Joint Commission

MAR 14 '14 AM 10:54

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DYER

Ben Youree, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE

CEO

TITLE

Sworn to and subscribed before me this 11th day of March, 2014 a Notary Public in and for Dyer County, Tennessee.

NOTARY PUBLIC

My commission expires 1-18-16

SUSAN STOVER
STATE OF TENNESSEE NOTARY PUBLIC
DYER COUNTY

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the State Gazette which is a newspaper of general circulation in Dyer County, Tennessee, on or before March 10, 2014 for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.,* and the Rules of the Health Services and Development Agency, that: Dyersburg Regional Medical Center owned and managed by Dyersburg Hospital Corporation intends to file an application for a Certificate of Need for the expansion of its cardiac catheterization services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures, and the initiation of such services. Dyersburg Regional Medical Center is located at 400 Tickle Street, Dyersburg, Dyer County, Tennessee. Dyersburg Regional Medical Center is licensed as a general hospital by the Tennessee Board for Licensing Healthcare Facilities. The licensed bed complement of the hospital will not be affected by this proposal. No major medical equipment is involved in this proposal. The estimated project cost is $367,763.00.

The anticipated date of filing the application is March 14, 2014.

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites and Harbison, PLLC, 401 Commerce Street, Suite 800, Nashville, Tennessee, 37219, 615-782-2228; jerry.taylor@stites.com

Signature

3-7-14
Date

==========

The published Letter of Intent contains the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

ORIGINAL
SUPPLEMENTAL-1

Dyersburg Regional Medical ctr.

CN1403-007

SUPPLEMENTAL RESPONSES

CERTIFICATE OF NEED APPLICATION

FOR

DYERSBURG REGIONAL MEDICAL CENTER

Project No. CN1403-007

Expansion Of Existing Cardiac Catheterization Service to Include Interventional Cardiac Catheterization

Dyer County, Tennessee

March 25, 2014

Contact Person:

Jerry W. Taylor, Esq.
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, Tennessee 37219
615-782-2228

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

1. **Section A, Item 3**

   Please provide the names of the owners (5% interest or greater) of Community Health System and indicate their percentage of ownership.

   Community Health Systems, Inc. is a publicly traded company with thousands of shareholders. The identification of those shareholders with 5% or greater shares is not readily available.

   Please list hospitals owned by Community Health Systems in Tennessee and Missouri.

   A list is attached following this page.

   Please discuss the proposed organizational and business relationships among these entities in such a manner that their affiliation with project can be understood. An organization chart will be helpful.

   Community Health Systems, Inc. is a publicly traded company. Through its various affiliated entities CHS owns, operates or leases 206 hospitals in 29 states as of February 2014. Twenty of these hospitals are in Tennessee. Each CHS hospital is operationally independent, with certain administrative support services supplied by CHS and its affiliates. Ownership information for the applicant and an organizational chart for CHS are attached following this page.

2. **Section A, Item 9 Bed Complement Data**

   The bed complement data chart is noted. Please complete the "Total Beds at Completion" column.

   A revised Bed Complement Data Chart is attached following this page as a replacement page for the application.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

Tennessee

Dyersburg Regional Medical Center, Dyersburg

Gateway Medical Center, Clarksville

Harton Regional Medical Center, Tullahoma

Haywood Park Community Hospital, Brownsville

Henderson County Community Hospital, Lexington

Heritage Medical Center, Shelbyville

Jamestown Regional Medical Center, Jamestown

Jefferson Memorial Hospital, Jefferson City

LaFollette Medical Center, LaFollette

Lakeway Regional Hospital, Morristown

McKenzie Regional Hospital, McKenzie

McNairy Regional Hospital, Selmer

Newport Medical Center, Newport

North Knoxville Medical Center, Powell

Physicians Regional Medical Center, Knoxville

Regional Hospital of Jackson, Jackson

SkyRidge Medical Center, Cleveland

Turkey Creek Medical Center, Knoxville

University Medical Center, Lebanon

Volunteer Community Hospital, Martin

Missouri

Moberly Regional Medical Center, Moberly

Northeast Regional Medical Center, Kirksville

Poplar Bluff Regional Medical Center, Poplar Bluff

Twin Rivers Regional Medical Center, Kennett

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

DYERSBURG HOSPITAL CORPORATION
OWNERSHIP INFORMATION

Name of Entity: **Dyersburg Hospital Corporation** (TN Corp.) (EIN: 42-1557536)
d/b/a Dyersburg Regional Medical Center
Corporate Address: 4000 Meridian Blvd., Franklin, TN 37067
Facility Address: 400 Tickle Street, Dyersburg, TN 38024

The disclosing entity is wholly owned by:
Community Health Investment Company, LLC (DE Ltd. Liability Co.) (EIN: 76-0152801)
4000 Meridian Blvd., Franklin, TN 37067

Which is wholly owned by:
CHS/Community Health Systems, Inc. (DE Corp.) (EIN: 76-0137985)
4000 Meridian Blvd., Franklin, TN 37067

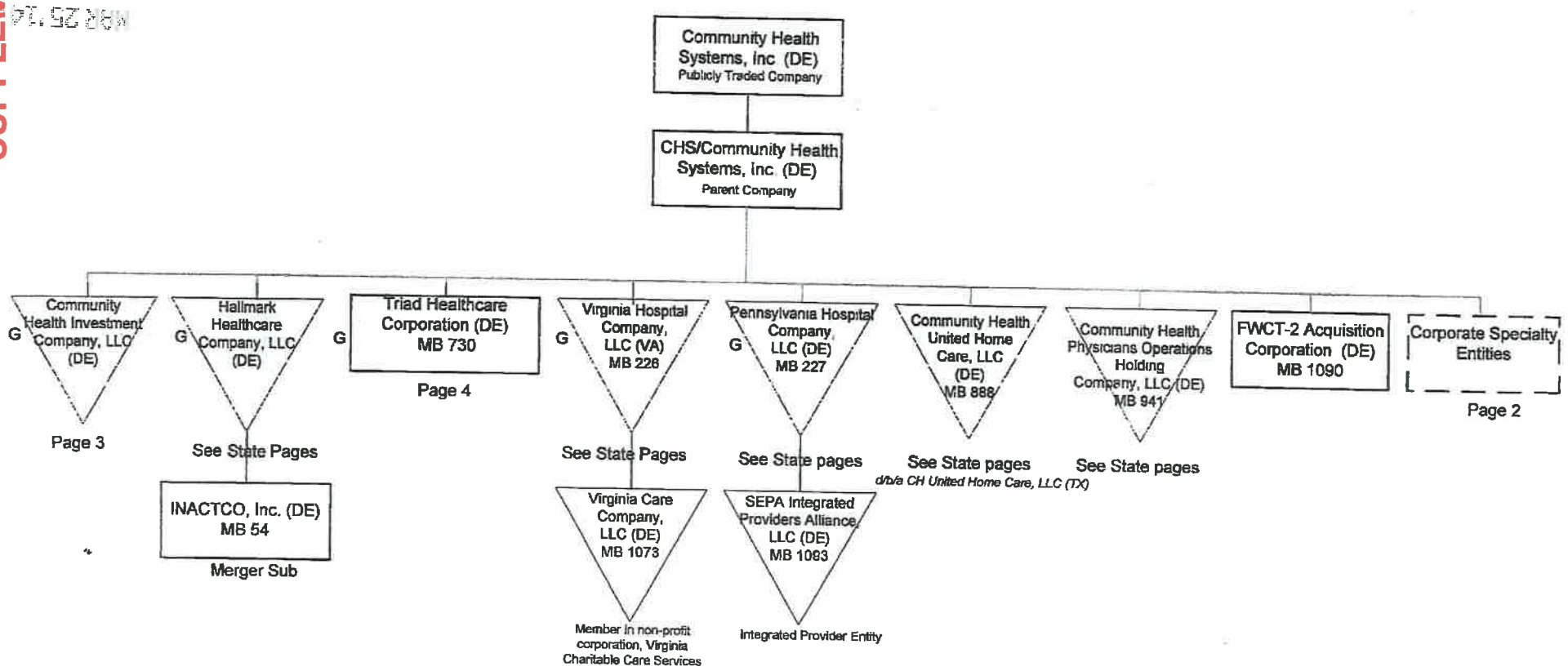
Which is wholly owned by:
Community Health Systems, Inc. (DE Corp.) (EIN: 13-3893191)
a publicly traded company, trading under the symbol of "CYH" on the NYSE
4000 Meridian Blvd., Franklin, TN 37067

Dyersburg Hospital Corporation d/b/a Dyersburg Regional Medical Center
The corporation's officers and directors are:

NAME	TITLE	STREET ADDRESS
W. Larry Cash	Director and President	4000 Meridian Blvd. Franklin, TN 37067
Martin Schweinhart	Director and Executive Vice President	4000 Meridian Blvd. Franklin, TN 37067
Rachel A. Seifert	Director, Executive Vice President and Secretary	4000 Meridian Blvd. Franklin, TN 37067
James W. Doucette	Senior Vice President and Treasurer	4000 Meridian Blvd. Franklin, TN 37067
Kevin Hammons	Senior Vice President	4000 Meridian Blvd. Franklin, TN 37067
Christopher G. Cobb	Assistant Secretary	4000 Meridian Blvd. Franklin, TN 37067

Community Health Systems

Organizational Chart



G = Guarantor under CHS/Community Health Systems, Inc. Credit Agreement and Community Health Systems, Inc. Indenture

Taxable Entity Key:

- Rectangles represent legal entities treated as corporations for tax purposes.
- Upside down triangles represent disregarded (single owner) entities for tax purposes.
- Dashed upside down triangles inside solid rectangle represent single owner entities electing to be a taxable association for tax purposes
- Regular triangles represent partnerships. If no percentage owned is indicated, the partnership is disregarded for tax purposes.

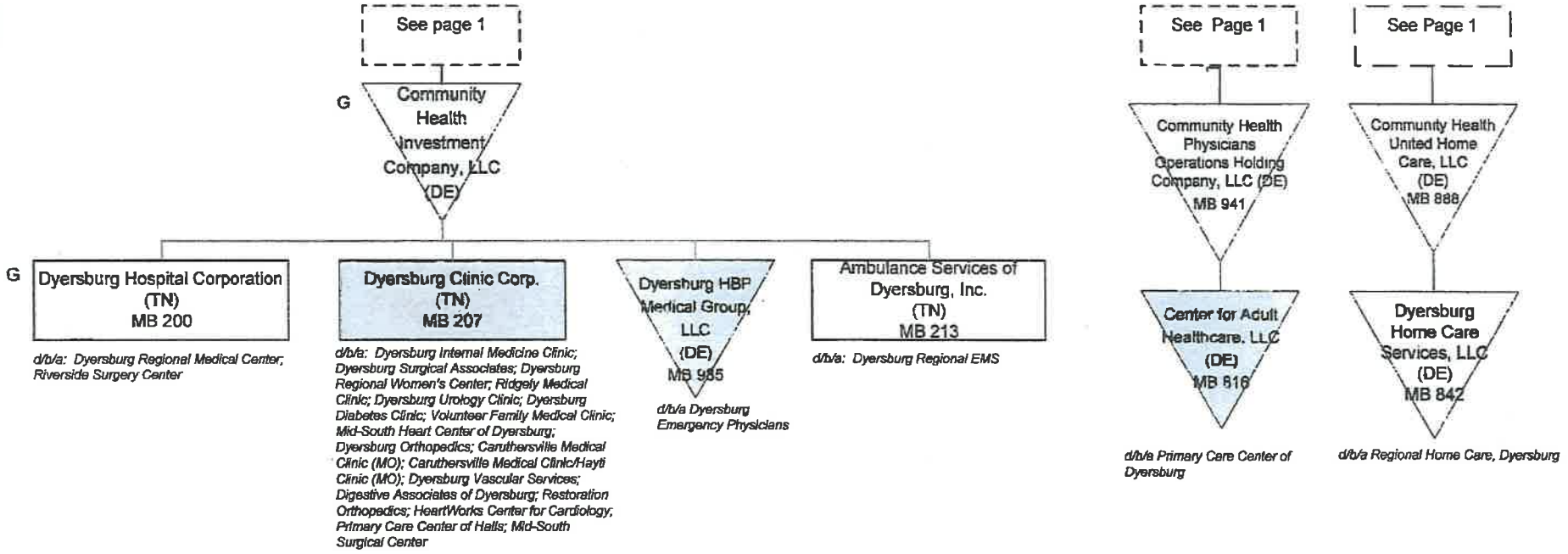
Color-Coding Key:

- = Hospital
- = Clinics/Physicians
- = Surgery Centers
- = Parent or Holdings Cos.
- = QHR and related
- = 50% or less ownership (non-consolidating)
- = Home Health/Hospice

12/31/13
Page 1

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

TENNESSEE
Dyersburg



9. Bed Complement Data

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical	147		60		147
B.	Surgical	20		15		20
C.	Long-Term Care Hospital					
D.	Obstetrical	18		18		18
E.	ICU/CCU	10		10		10
F.	Neonatal	10		10		10
G.	Pediatric	10		4		10
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds	10		0		10
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	**225**	**0**	**117**	**0**	**225**

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

3. **Section A, Applicant Profile, Item 13**

The applicant's contractual relationships with Bluecare, United Community Healthcare Plan and TennCare Select are noted. However, new TennCare contracts will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United Healthcare. Please indicate if the applicant intends to contract with AmeriGroup. If so, what stage of contract discussions is the applicant involved with AmeriGroup?

DRMC has a strong interest in being part of the AmeriGroup network when it goes state-wide. DRMC is in the early stages of discussions with AmeriGroup representatives towards that end.

Please clarify if the applicant has a Medicaid contract with Missouri.

Yes, DRMC is a contracted Medicaid provider with the State of Missouri.

What type of contracts does DRMC have with Missouri insurance organizations?

DRMC does not maintain contracts with any Missouri based health plans. Most plans will pay normal reimbursement for emergency treatment or admissions. Elective admissions may be treated by a Missouri insurer as out-of-network.

4. **Section B, Project Description, Item 1**

Your response is noted. Please provide an executive summary not to exceed two (2) pages. Please list the following areas as headers and address each area under the appropriate header: proposed services and equipment; ownership structure; service area; need; existing resources; project cost; funding; financial feasibility; and staffing.

A revised Executive Summary is attached following this response.

What are the hours of DRMC's cardiac catheterization lab?

The existing cardiac catheterization lab's normal operating hours are Monday through Friday from 7:00am to 4:00pm.

What plans does the applicant have for therapeutic catheterization procedures during non-operating times?

DRMC plans to have on-call availability for after-hours Monday through Friday, weekends, and observed holidays. The on-call availability will include an interventional cardiologist, and cardiac catheterization lab team comprised of nursing and technical personnel who will respond before and after the "normal operating hours" listed above.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE:

Ownership Structure

Dyersburg Regional Medical Center ("DRMC") is a 225-bed community hospital located in Dyersburg, Tennessee. DRMC is owned by Dyersburg Hospital Corporation, which is owned by an affiliate of Community Health Systems, Inc. ("CHS"), which is headquartered in Franklin, Tennessee. CHS owns, operates or leases 206 hospitals in 29 states as of February 2014. As a member of CHS, DRMC is in a position to benefit from the experience gained by health system hospitals, which will be particularly useful in regards to the applicant's proposal to expand its service capabilities with this application.

Service Area

DRMC serves the needs of over 190,000 people residing in a in a 7-County area in west Tennessee and Missouri. The Counties in DRMC's service area include Crocket, Dyer, Gibson, Lake, Lauderdale, and Obion Counties in Tennessee, and Pemiscot County in Missouri. Currently, DRMC is one of only two hospitals located within this 7-County area that have a cardiac catheterization lab, with neither hospital having therapeutic cardiac catheterization ("PCI") or open heart surgery capabilities. When evaluating the demographics of the DRMC service area, it is clear that the applicant is providing healthcare services to a patient population that has significantly higher rates of mortality from heart disease and acute myocardial infarctions ("AMI," "STEMI," or heart attack), higher rates of poverty, and a higher percentage of elderly when compared to the state and the nation. In addition, all of the Counties in DRMC's service area are designated as medically underserved areas ("MUAs") by the Health Resources and Services Administration ("HRSA"). MUAs are characterized by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population[1]. These factors contribute to a population with a heightened need for improvements to access to care that will aid in improving the health status of the community.

Existing Resources

Patients that require treatment options beyond the scope of services offered by DRMC -- PCI or open heart surgery -- are transferred or referred to a provider based in a County outside of the service area. This situation causes delays to treatment, adds unnecessary costs to patient care with increased EMS transports over longer distances, and places residents in the DRMC service area in a situation that involves unnecessary risks. According to data from the National Registry of Myocardial Infarction ("NRMI"), patients who are transferred for primary PCI are treated 71 minutes later than patients who receive primary PCI locally. Additionally, the NRMI registry demonstrates that a door-to-balloon time of 2.5 to 3 hours, as seen in patients transferred for PCI, is associated with a 60% increase in risk-adjusted mortality compared with a door-to-balloon time of less than 2 hours[2]. With the approval to initiate PCI services at DRMC, patients that reside in the service area

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[1] "Find Shortage Areas: MUA/P by State and County," Health Resources and Services Administration, http://muafind.hrsa.gov/index.aspx, Accessed 23 January 2014.

[2] Reference: Wharton, Thomas P., "The Case for Community Hospital Angioplasty," Circulation. 2005; 112: 3509-3534.

would now be able to travel to a hospital offering PCI services in less than 1 hour, with the majority of residents able to travel to DRMC in less than 30 minutes.

Proposed Services, Equipment, and Project Cost

Due to the initiation of a diagnostic cardiac catheterization service at DRMC in 2009, the applicant would require a relatively minimal investment to advance its capabilities to offer PCI. DRMC will not need to renovate its physical plant to offer the service, and therefore has no renovation or construction costs associated with this project. The total investment in equipment to introduce PCI services at DRMC is $200,000. Given the relatively low cost of entry, the initiation of a PCI services would be financially viable decision for the applicant. Additionally, PCI services will allow DRMC to better utilize existing space and equipment that is already in place for the diagnostic catheterization program. At the same time, the inability to advance DRMC's capabilities to offer PCI services has the potential to cause erosion to the volume of diagnostic catheterization currently performed.

Staffing

DRMC has a complement of experienced personnel in place to manage the existing diagnostic cardiac catheterization lab. With approval of this application, DRMC plans to add the additional personnel required to ensure the hospital has an adequate number of nurses and radiology technicians to continue to provide services during normal hours, but now also to care for an emergent patient population that can present to the hospital at any time.

Financial Feasibility and Funding

With an existing diagnostic cardiac catheterization service at DRMC, the required investment to advance services to offer PCI is considered relatively minimal. The project will not require changes to the current facility, which reduces the investment significantly. The total cost for equipment for this project is estimated to total $200,000. With a limited investment required to expand DRMC's capabilities in its existing cardiac catheterization lab space, the applicant expects to achieve a positive ROI even within the first full year of operation. This project is expected to be fully funded using the applicant's cash reserves.

Need

Through an evaluation of patient transfer data, it is clear that DRMC has a high volume of patients with cardiovascular disease presenting to the hospital. In fact, in 2013 alone DRMC transferred over 1,000 patients for cardiovascular reasons. With non-invasive testing and diagnostic catheterization capabilities on-site, clearly a number of patients presenting to DRMC are considered high risk or are in need of a higher level of cardiac care that is not offered at the hospital today. The market potential for an expansion in capabilities to offer PCI services indicates DRMC will meet the established volume thresholds for a PCI program within its first full year of operation. With no PCI program in the DRMC service area, DRMC, with the approval to offer PCI, will have no effect on provider volumes for those that are located in the seven counties it serves. Additionally, given the significantly high mortality rates for heart disease and AMI in the region, a new PCI program will improve access to necessary care while having a marginal effect on programs located outside of the DRMC market.

In summary, the proposed project will improve access to the recognized standard of care in the treatment of AMI, is economically feasible, provides a necessary service to Tennesseans, and reduces unnecessary risks to the patient population DRMC serves. For these reasons and more, the applicant requests that the Tennessee Health Services and Development Agency approve its

application to expand its capabilities to offer therapeutic cardiac catheterization services to the communities it serves.

5. **Section B, Project Description, Item II A.**

The applicant states the inability to provide therapeutic cardiac catheterization (PCI) services will have the potential to erode DRMC's diagnostic catheterization volumes thus impacting the program's long-term viability. With this in mind, how has the volumes and viability of the program been impacted since the implementation of CN-0509-83A for the Initiation of Diagnostic Cardiac Catheterization without therapeutic catheterization?

Since the initiation of diagnostic cardiac catheterization services at DRMC, the hospital has experienced positive responses from service area residents now that patients can receive a higher level of cardiac care closer to home. At the same time, this logical advancement in services put DRMC in a better position to secure cardiologist coverage for the hospital. However, as the recognized standard of care has changed and as cardiac catheterization labs offering PCI without surgery on-site have been proven safe, DRMC has been challenged to maintain consistent cardiology coverage over time due to limitations on the program's capabilities. Additionally, patients can reasonably question why they would need to potentially endure two cardiac catheterization procedures when the applicant could be in a position to provide therapeutic treatment options in the same setting.

As fewer cardiologists come out of training with just invasive ("diagnostic cardiac catheterization") capabilities, DRMC expects this challenge to continue for labs without therapeutic capabilities. Since the 1990's, the number of cardiologists coming out of training has been below historic levels. Annually, roughly 750 physicians graduate from general cardiovascular disease training programs, with nearly 50% of them obtaining further training in interventional cardiology or clinical care electrophysiology[1]. This statistic alone may reasonably exclude DRMC from attracting half of the new cardiologists coming out of training given the absence of therapeutic cardiac catheterization capabilities at the hospital. In fact, as referenced in this application, a number of cardiologists working in west Tennessee have expressed interest in working at DRMC if the program expands to offer therapeutic cardiac catheterization. Without these capabilities, these physicians would not be interested in actively practicing at the hospital on a consistent basis. The demands on these specialists' time are many, and practicing at a lab with just diagnostic capabilities would require these physicians to endure a significantly greater travel burden while actively practicing at a site offering therapeutic treatments as well in an effort to maintain their interventional skillset.

This situation would place DRMC at a disadvantage when working to secure cardiology coverage for the hospital. That, coupled with the current inability to offer the standard of care to STEMI patients has the potential to erode diagnostic volumes and thus impact the program's long term viability.

6. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 3**

The transfer agreements to three (3) hospitals are noted. Please complete the following table:

A completed table appears following this response.

[1] *J Am Coll Cardiol.* 2009;54(13):1195-1208. doi:10.1016/j.jacc.2009.08.001

Hospital	Distance from DRMC Ground miles / Air Nautical miles	Emergency travel time from DRMC to receiving facility by air in minutes flight time / Total transfer time*	# of transfers in 2013 by air	Emergency travel time from DRMC to receiving facility by ground ambulance in minutes	# of transfers in 2013 by ground	# of transfers in 2013 for open heart surgery	# of transfers in 2013 for theraputic catheterization	$ of transport by Ground Ambulance / Air Ambulance
Regional Hospital Jackson	49.7 / 33.1	19.9 / 46.9	12	49	443	0	20	$1681.80 / $21,000
Methodist University	77.2 / 60.6	38.8 / 65.8	1	81	51	1	1	$2066.80 /$25,000
St Francis - Memphis	87 / 64.7	36.3 / 63.3	2	85	10	0	0	$2204.00 /$25,000
Vanderilt University	173.7 / 125.5	75.3 / 102.3	2	155	15	1	0	$3417.80 /$28,000
		* Total transfer time includes loading and unloading on both ends. Flight time is actual time in the air	Total flights in 2013 = 174 (31 of these were from the scene)			* DRMC does not know definitively which of these transfers resulted in an open heart surgery. This is the best estimation based on available information.	* DRMC does not know definitively which of these transfers resulted in a PCI procedure. This is the best estimation based on available information.	*This represents charges and not actual cost

It appears Vanderbilt Medical Center is not within the 60 minute compliance for patient transfer. Please clarify the reason the applicant does not have a transfer agreement with a closer Shelby County tertiary hospital with similar services.

DRMC does have a transfer agreement with St. Francis Hospital, which is a Shelby County Hospital with similar services. A copy of the transfer agreement is included in Attachment C Specific Cardiac Cath Criteria (3) Transfer Agreements in the application.

Please discuss the services available at Vanderbilt Medical Center, the Regional Hospital of Jackson and St. Francis Hospital for patients who are transferred for higher levels of heart care from DRMC.

Vanderbilt Medical Center located in Davidson County offers a full complement of cardiovascular services, including: general cardiology, diagnostic and therapeutic cardiac catheterization, open heart surgery, congenital heart care, heart transplant services, trans-catheter aortic valve replacement, and cardiac rehabilitation services.

St. Francis Hospital located in Shelby County offers a full complement of cardiovascular services, including: general cardiology services, diagnostic and therapeutic cardiac catheterization, open heart surgery, and cardiac rehabilitation services.

Regional Hospital of Jackson located in Madison County offers a more limited complement of cardiovascular services, including: general cardiology, diagnostic and therapeutic cardiac catheterization, and cardiac rehab services.

It appears the three provided hospital transfer agreements were signed from March 2013 to May 2013. Please list the prior hospital transfer agreements for DRMC from the implementation of CN0509-083A of May 4, 2010 to March 2013.

The hospital is unable to locate any such transfer agreements prior to those provided. All of the hospital's transfer agreements were recently updated, and that is why the ones provided all had signature dates between March and May of 2013.

If the hospitals with transfer agreements with DRMC prior to March 2013 are different from the existing hospitals, why did the DRMC seek other hospitals to transfer heart patients?

N/A. Please see immediately preceding response.

Please provide a letter of interest from a Madison and/or Shelby County hospital regarding a possible transfer agreement specific to open heart surgery.

Not all hospitals require a transfer agreement be specific to open heart surgery. DRMC has transferred patients to both West Tennessee Health Care d/b/a Jackson Madison County General Hospital (Madison County) and St. Francis Hospital (Shelby County) for open heart surgery. A letter on behalf of Methodist University Hospital expressing interest in entering into such a Transfer Agreement with DRMC is attached following this response.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

Methodist Healthcare

March 21, 2014

Ben Youree
Chief Executive Officer
Dyersburg Regional Medical Center
400 East Tickle Street
Dyersburg, TN 38024

RE: Cardiothoracic Surgical Coverage

Dear Mr. Youree,

Methodist University Hospital will provide cardiothoracic surgical coverage for Dyersburg Regional Medical Center through an Emergent Transfer Agreement. A definitive agreement will be executed in the near future when the parties reach mutually agreeable terms.

Respectfully,

James R. Carter, Jr., FACHE
Chief Operating Officer

cc: file

7. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 7**

   Please discuss DRMC's plan to maintain qualified cardiologist for the proposed services.

   There are two categories of cardiologists involved in this project: (1) the invasive cardiologists who are performing the diagnostic procedures now at DRMC, and (2) the interventional cardiologists who will perform the interventional PCI procedures if this application is approved.

   The invasive cardiologists now on staff and performing diagnostic procedures will be maintained under the current arrangements and will continue performing diagnostic procedures even if and when this application is approved.

   The interventional cardiologists will be recruited and brought onto the medical staff to perform the interventional procedures if and when this application is approved. Several interventional Cardiologists that meet these guidelines have expressed an interest in working at a new PCI program at DRMC, but without the approval to proceed it is deemed premature at this point to contract with these eligible physicians. DRMC intends to maintain compliance regarding the minimum physician requirements of at least two (2) interventional cardiologists with at least one having performed an average of 75 therapeutic cardiac procedures over the most recent five year period. DRMC affirms the cardiologists that will be providing therapeutic cardiac service will be either board eligible or board certified in cardiology and other relevant cardiac subspecialties.

   If a cardiologist unexpectedly leaves DRMC, what would DRMC do to ensure the continuity of the proposed service?

   An unexpected loss of a key medical staff member is always a possibility at any hospital, and the executive management at DRMC is prepared to take all necessary steps to ensure continuity of patient care is maintained during any period of unexpected physician loss while simultaneously putting in place recruitment efforts to replace the medical staff physician. Of course it is next to impossible to recruit an interventional cardiologist until the hospital has CON approval or an interventional program is in place. As discussed above, interventional cardiologists meeting the education, training and experience requirements will be recruited and maintained on the medical staff if this application is approved.

8. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 9**

   Table 5 of distances to nearest PCI centers and cardiac services are noted. It appears the nearest facility with open heart surgery capabilities is Jackson-Madison County General Hospital in Jackson, TN. Please explain why there is not a transfer agreement with this facility when it is best to be under 60 minutes transfer time for heart patients.

   A transfer agreement is not necessary for the transfer of patients for open heart surgery at West Tennessee Healthcare d/b/a Jackson Madison County General Hospital, because WTHC has in effect an Auto-Acceptance Policy for Cardiology-STEMI Transfers. A copy of the policy is attached following this response. DRMC transfers a number of heart attack patients to Jackson Madison County General Hospital.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

West Tennessee Healthcare
WTHVC POLICY AND PROCEDURE

TITLE: Auto-Accept for Cardiology-Assigned & Unassigned – STEMI Transfer	**POLICY NO.:**
	PAGE(S): 2
	EFFECTIVE: 4/23/2012
	REVIEWED: 11/1/2013
CATEGORY: Care Coordination	**REVISED:** 11/1/2013

PURPOSE: To establish an Auto-Acceptance process for referring facilities to expedite E.D. to E.D. transfers of Cardiology/STEMI patients to Jackson Madison County General Hospital. (JMCGH).

POLICY: West Tennessee Heart and Vascular Center and Emergency Department at JMCGH initiated the Auto-Accept process for Cardiology transfers only. Once contacted by the referring facility of a patient needing Cardiology services at JMCGH, the IC and/or ED physician can accept the patient directly. Cardiologists are responsible to respond according to assigned and unassigned cardiology protocols. JMCGH Emergency Department is always open 24/7 and the West Tennessee Heart and Vascular Center has both a STEMI, as well as a General Cardiology on call physician 24/7.

PROCEDURE:

1. Once the physician at a referring facility feels the need to transfer the patient for suspected STEMI and higher level of Cardiology care, that facility will contact the JMCGH Call Center at 1-800-601-0830 (Physician Referral Line)
2. The Call Center will be prompted to ask the referring facility the following questions:
   - ✓ Do they have ST Elevation?
   - ✓ Do they have a Cardiologist?
   - ✓ Fax EKG to 731-541-9595
3. The Call Center will inform the transferring ED to "Prepare the patient for transport while she gets IC and EDP on phone conference to discuss Reperfusion strategy".
4. The Call Center will then contact JMCGH IC and ED physician to inform them of STEMI transfer and if Assigned or Unassigned.
5. The Call Center will confirm that JMCGH EDP has a copy of EKG.
6. The Call Center will then connect 4-way call including IC, referring EDP, and JMCGH EDP to discuss Initial Reperfusion Strategy.
7. The IC/ED physician will accept the patient and follow the attached algorithms.

8. The Call Center contacts PBX Operator to activate JMCGH Cardiac Cath Lab.
9. The nurse at the referring facility will call patient report to Call Center.

EDUCATION: Explanation and Education provided to referring facilities of the appropriate transfer process; ER physicians, ER staff, and Call Center staff will be educated regarding appropriate transferring process for Auto-Accept Cardiac patients.

DOCUMENTATION: All calls to the call center are recorded. The call between the referring physician, IC and the ED physician will be recorded via the conference lines. The call will be documented by the Call Center nurse in Relay Care transfer software and the patient report information will be documented in First Net – "Coming Attractions" section for use by the accepting facility staff. When the patient arrives at JMCGH Emergency Room, they will be registered and receive an account number so that this information can be attached to the patient's record. Records from the transferring facility will be scanned into the patient's chart upon arrival to JMCGH. If EMS performs an ECG within 1 hour of arrival to JMCGH, it may be scanned into the patient's record as the "initial" EKG. If the EKG was done more than one hour prior to arrival, it will be necessary to repeat the EKG upon arrival to E.D.

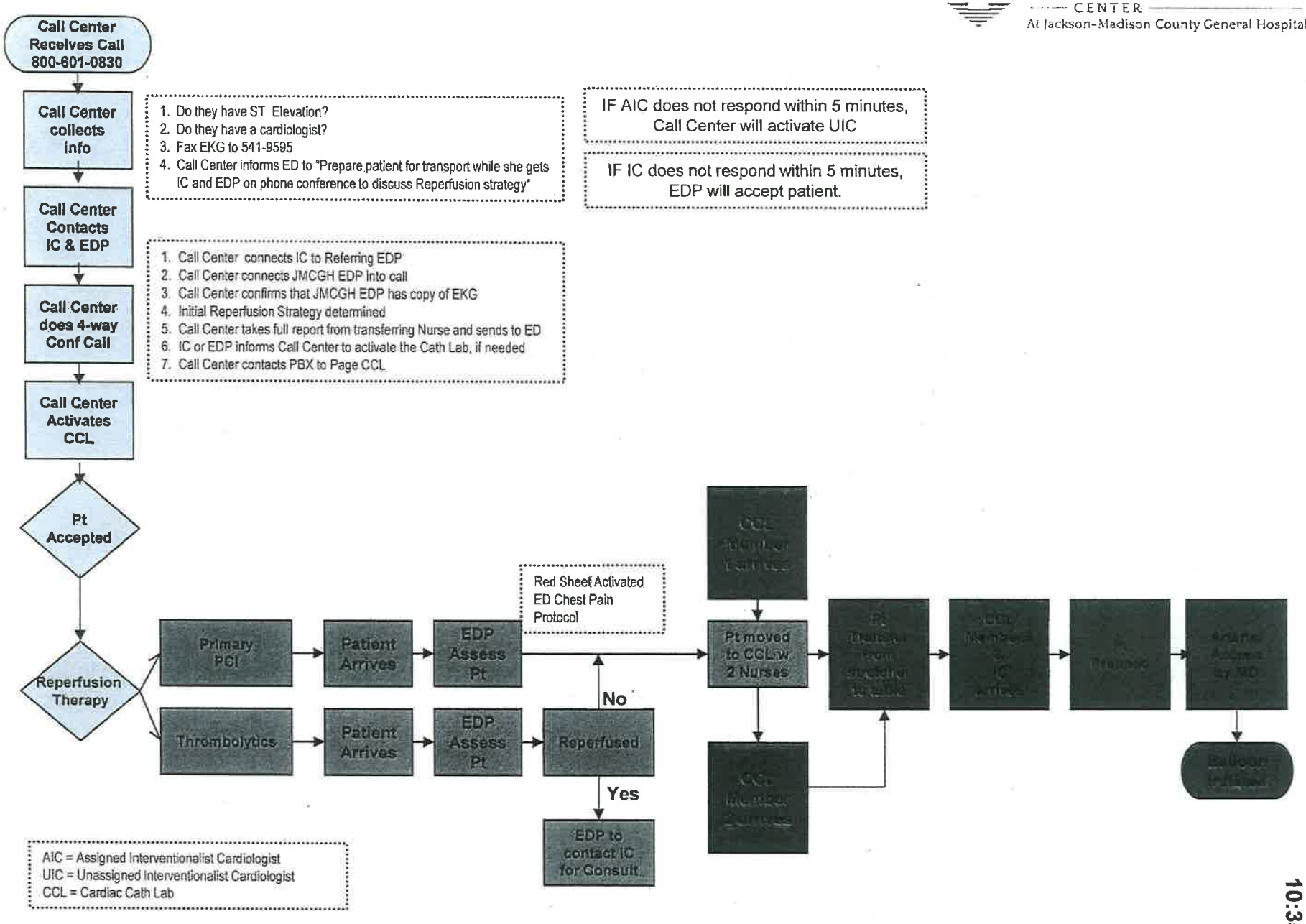
RELATED INFORMATION: Refer to algorithms for Auto-Accept for Cardiology – Assigned and Unassigned – General Cardiology, and STEMI/NSTEMI flowcharts.

Deann Montchal, Vice-President of Hospital Services

Dr. John Baker, Chest Pain Center Accreditation Medical Director

Auto Accept for Cardiology Patients – Assigned and Unassigned – STEMI Transfer

WEST TENNESSEE HEART & VASCULAR CENTER
At Jackson-Madison County General Hospital



SUPPLEMENTAL- # 1
March 25, 2014
10:35am

Please request the Age Group-Specific Historical State Cardiac Catheterization Utilization Rate from the Tennessee Department of Health based upon information from the Hospital Discharge System. Please refer to page 11 of the State Health Plan Certificate of Need Standards and Criteria for Cardiac Catheterization Services that defines "Age Group-Specific Historical State Utilization Rate" for the purpose of defining need in the proposed service area.

Please note: As indicated in the State Health plan, the age group-specific historical state utilization rate will be calculated separately for diagnostic and therapeutic catheterization cases and will be a running average. The Department of Health shall maintain the ongoing age group-specific historical state utilization rate to avoid breaches of patient confidentiality.

The applicant made numerous unsuccessful attempts to obtain this data from the Department of Health, and apparently such data is not maintained and/or not available. This issue is affirmatively addressed by the applicant on page 22 of the application.

These efforts began in approximately November 2013 and continued through February of 2014 without resolution. When it was apparent the data was not available, the applicant incorporated an alternative approach to determine need that relied on actual transfer data for cardiac reasons. In addition, DRMC further validated this approach when comparing the calculated service area utilization rate to that of the nation. With a lower utilization rate for therapeutic cardiac catheterization procedures in the area (as compared to the nation), the applicant was confident that the approach used was a conservative one. The methodology used by the applicant is reasonable and logical, and takes into account the service area utilization rate compared to the national utilization rate. The only data set missing, because it is not available, is the age-specific utilization rates. Please see pages 22-24 of the application.

Please clarify how the applicant came to the conclusion that 25% of patients transferred from DRMC received a therapeutic catheterization procedure.

Through an evaluation of national discharge data sets from the Agency for Healthcare Research and Quality ("AHRQ") coupled with an understanding of the potential treatment options this transported cardiac patient population may receive, the applicant estimated that approximately 47% of this EMS transported patient group would consist of complex patients managed medically, 10% to open heart surgery, 33% to PCI, and 10% to another procedure. In an effort to take a more conservative approach, DRMC reduced this conversion rate to PCI from 33% to just 25% of this patient group. The 25% is just an estimate, but the applicant believes it is a reliable, conservative estimate.

9. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 9**

In table 10 there is a slight calculation error in Year Two "Total Adult Cardiac Cath Lab Cases". Please revise.

A revised Table 10 as part of Replacement page 26 is attached following this response.

Table 10 – DRMC's Historic and Projected Cardiac Catheterization Volumes and Lab Utilization

Dyersburg Regional Medical Center Utilization Statistics	HISTORIC			PROJECTED	
Service	2011	2012	2013	Year 1	Year 2
Diagnostic Cardiac Cath	376	322	218	393	494
Therapeutic Cardiac Cath	0	0	0	131	165
Total Adult Cardiac Cath Lab Cases	376	322	218	524	659
DRMC Cardiac Cath Labs	1	1	1	1	1
Volume of Weighted Cases Available (2,000 per lab)	2,000	2,000	2,000	2,000	2,000
DRMC Weighted Cases	376	322	218	655	824
Lab Utilization	18.8%	16.1%	10.9%	32.8%	41.2%

* The decline in volume in 2012 and 2013 was due to the departure of a Cardiologist form the medical staff. From May 2012 through August 2013, DRMC had one full-time Cardiologist on active staff at the hospital. In August 2013, a second full-time Cardiologist joined the active staff at DRMC.

15. Open Heart Surgery Availability: Acute care facilities proposing to offer adult therapeutic cardiac catheterization services shall not be required to maintain an on-site open heart surgery program. Applicants without on-site open heart surgery should follow the most recent American College of Cardiology/American Heart Association/Society for Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines). As of the adoption of these Standards and Criteria, the latest version of this document (2007) may be found online at: *http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.107.185159*
Therapeutic procedures should not be performed in freestanding cardiac catheterization laboratories, whether fixed or mobile. Mobile units may, however, perform therapeutic procedures provided the mobile unit is located on a hospital campus and the hospital has on-site open heart surgery. In addition, hospitals approved to perform therapeutic cardiac catheterizations without on-site open heart surgery backup may temporarily perform these procedures in a mobile laboratory on the hospital's campus during construction impacting the fixed laboratories.

RESPONSE: DRMC will maintain a formal transfer agreement with an open heart tertiary center as referenced above in number 3 from the *"Standards and Criteria Regarding Certificate of Need Applications for All Cardiac Catheterization Services"* DRMC will maintain compliance with the most recent American College of Cardiology/American Heart Association/Society for Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention. (ACC/AHA/SCAI Guidelines). Additionally, DRMC plans to perform PCI procedures in its existing cardiac catheterization lab that is currently located within the hospital's facility.

16. Minimum Physician Requirements to Initiate a New Service: The initiation of a new therapeutic cardiac catheterization program should require at least two cardiologists with at least one cardiologist having performed an average of 75 therapeutic procedures over the most recent five year

10. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 15

The applicant states a formal transfer agreement with an open heart tertiary center will be maintained. Please clarify the name of the open heart tertiary center the applicant is referring.

Vanderbilt University Medical Center
St. Francis Hospital
An Agreement with Jackson Madison County General Hospital is not necessary (see response to Supplemental Question 8).

11. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 16

Please clarify if the existing two DRMC cardiologists meet the minimum physician requirements to initiate the proposed therapeutic cardiac catheterization program.

There are two categories of cardiologists involved in this project: (1) the invasive cardiologists who are performing the diagnostic procedures now at DRMC, and (2) the interventional cardiologists who will perform the interventional PCI procedures if this application is approved.

The invasive cardiologists now on staff and performing diagnostic procedures will be maintained under the current arrangements and will continue performing diagnostic procedures even if and when this application is approved. The existing two DRMC cardiologists do not meet the minimum physician requirements, because they are invasive cardiologists and do not and will not perform the interventional procedures.

The interventional cardiologists will be recruited and brought onto the medical staff to perform the interventional procedures if and when this application is approved. Several interventional Cardiologists that meet these guidelines have expressed an interest in working at a new PCI program at DRMC, but without the approval to proceed it is deemed premature at this point to contract with these eligible physicians. DRMC intends to maintain compliance regarding the minimum physician requirements of at least two (2) interventional cardiologists with at least one having performed an average of 75 therapeutic cardiac procedures over the most recent five year period. DRMC affirms the cardiologists that will be providing therapeutic cardiac service will be either board eligible or board certified in cardiology and other relevant cardiac subspecialties.

Please provide the following information for the two existing DRMC cardiologists: 1) estimated number of diagnostic cardiac procedures conducted for the past five (5) years, and 2) the estimated number of therapeutic cardiac procedures conducted for the past five (5) years.

Dr. Geha	Pts. Diagnostic CC Only	Procedures Diagnostic CC Only	Total Pts.	Total Procedures*
2011	52	328	59	346
2012	160	1006	196	1100
2013	177	1042	199	1095
2014 (thru Feb.)	20	91	23	97

Dr. Shahbaz	Pts. Diagnostic CC Only	Procedures Diagnostic CC Only	Total Pts.	Total Procedures
2011				
2012				
2013	41	172	48	194
2014 (thru Feb.)	13	61	15	65

*Total Procedures include cardiac procedures that are not catheterizations, for example, cardioversions and transesophageal echocardiogram.

Please provide the names and credentials (i.e., curriculum vitae's and Board Certificates) for the physicians on the hospital's medical staff who will be performing these procedures. Please note those physicians who are board certified invasive and/or interventional cardiologists.

There are no physicians on the hospital staff who will be performing the interventional procedures. There are two categories of cardiologists involved in this project: (1) the invasive cardiologists who are performing the diagnostic procedures now at DRMC, and (2) the interventional cardiologists who will perform the interventional PCI procedures if this application is approved.

The invasive cardiologists now on staff and performing diagnostic procedures will be maintained under the current arrangements and will continue performing diagnostic procedures even if and when this application is approved. The existing two DRMC cardiologists do not meet the minimum physician requirements, because they are invasive cardiologists and do not and will not perform the interventional procedures.

The interventional cardiologists will be recruited and brought onto the medical staff to perform the interventional procedures if and when this application is approved. Several interventional Cardiologists that meet these guidelines have expressed an interest in working at a new PCI program at DRMC, but without the approval to proceed it is deemed premature at this point to contract with these eligible physicians. DRMC intends to maintain compliance regarding the minimum physician requirements of at least two (2) interventional cardiologists with at least one having performed an average of 75 therapeutic cardiac procedures over the most recent five year period. DRMC affirms the cardiologists that will be providing therapeutic cardiac service will be either board eligible or board certified in cardiology and other relevant cardiac subspecialties.

12. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 18**

The applicant states a cardiologist departed from DRMC in 2012. Please clarify if the cardiologist left because of the lack of therapeutic cardiac catheterization capabilities at DRMC.

No, that was not the reason for the departure of the cardiologist.

13. **Section C, Need, Item 4.A.**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

Census Bureau, please complete the following table and include data for each county in your proposed service area.

A table with the requested data appears below:

Variable	*Crockett*	*Dyer*	*Gibson*	*Lake*	*Lauderdale*	*Obion*	*Service Area (Counties based in TN)*	*TN*
Current Year (2014), Age 65+*	2,550	6,273	8,788	1,134	3,834	5,922	28,501	981,984
Projected Year (2016), Age 65+*	2,602	6,550	8,991	1,183	5,190	6,101	30,617	1,042,071
Age 65+, % Change	2.0%	4.4%	2.3%	4.3%	35.4%	3.0%	7.4%	6.1%
Age 65+, % Total (PY)	17.8%	17.1%	17.4%	12.3%	19.1%	19.5%	17.7%	15.5%
CY, Total Population*	14,596	38,218	51,102	9,732	27,341	31,453	172,442	6,588,698
PY, Total Population*	14,620	38,301	51,695	9,605	27,188	31,297	172,706	6,710,579
Total Pop. % Change	0.2%	0.2%	1.2%	-1.3%	-0.6%	-0.5%	0.2%	1.8%
TennCare Enrollees*	3,449	9,161	11,221	1,941	6,976	6,514	39,263	1,194,860
TennCare Enrollees as a % of Total Population(CY)	23.6%	24.0%	22.0%	19.9%	25.5%	20.7%	22.8%	18.1%
Median Age**	39.6	39.3	39.9	38.3	36.4	41.1	Not Avail.	38
Median Household Income**	$37,601	$38,167	$36,981	$26,212	$32,987	$40,516	Not Avail.	$44,140
Population % Below Poverty Level**	19.2%	19.2%	18.6%	30.3%	26.1%	17.1%	Not Avail.	17.3%

*Source: Tennessee Department of Health Population Projections, 2010-2020

**Source: TennCare 2013 Enrollment Data. Data derived from "Midmonth Report for November 2013"

***Source: U.S. Census Bureau: 2010 Demographic Profile Data

****Source: U.S. Census Bureau: State and County QuickFacts. Data representative of 2008-2012

Variances exist between the median household income and percent of population below the poverty level figures reported in this response and the CON application due to differing sources for data. However, in both cases, all counties in the DRMC service area are report median household incomes that are below the state average. In this data set, 5 of 6 service area counties exceed the state's percentage of population that is below the poverty level. This data suggests DRMC serves a population that is older and at lower income levels than the state average.

14. Section C, Need, Item 5

Table 17 on page 36 is noted. However, there appears to be calculation errors in the grand total of the chart. Please revise.

A revised Table 17 is attached following this response.

Table 17 – Cardiac Utilization Trends 2010-2012, Dyersburg Regional Medical Center Proposed Service Area[1]

Hospitals in Dyersburg Regional Medical Center's Proposed Service Area	Cardiac Utilization Trends (volume of patients)		
	2010	2011	2012
Baptist - Lauderdale	**0**	**0**	**0**
Diagnostic Cardiac Catheterization ("Cath")	0	0	0
Percutaneous Transluminal Coronary Angioplasty ("PTCA")	0	0	0
Stents	0	0	0
Baptist - Union City	**54**	**37**	**31**
Cath	54	37	31
PTCA	0	0	0
Stents	0	0	0
Dyersburg Regional Medical Center	**376**	**326**	**275**
Cath	376	326	275
PTCA	0	0	0
Stents	0	0	0
Gibson General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0
Stents	0	0	0
Humboldt General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0
Stents	0	0	0
Milan General Hospital	**0**	**0**	**0**
Cath	0	0	0
PTCA	0	0	0
Stents	0	0	0
Grand Total	**430**	**363**	**306**

[1] Data Sources: Tennessee Department of Health, Joint Annual Report of Hospitals 2010-2012; DRMC internal discharge data for DRMC volume to reflect patients rather than procedures

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

15. Section C, Need, Item 6

Table 21 on page 39 is noted. However, there appears to be slight calculation errors in the DRMC PCI volume for Year 1 and Year 2. If needed, please revise.

Table 22 is noted. However, there appears to be a slight calculation error in the number of projected total adult cardiac cath lab cases in Year 2. If needed, please revise.

Revised Table 21 and revised Table 22 are attached following this response.

Table 21 – DRMC PCI Volume Projections

	2013		Year 1 (2015)	Year 2 (2016)	Year 3 (2017)
PCI Volume in DRMC Service Area	386		392	395	398
Projected DRMC Market Share*	0%		33.33%	41.67%	50.00%
DRMC PCI Volume	0		131	165	199

**Projected market share is displayed to reflect just two decimal points although the actual figure continues beyond this point.*

Table 22 – DRMC's Historic and Projected Cardiac Catheterization Volumes and Lab Utilization

Dyersburg Regional Medical Center Utilization Statistics	HISTORIC			PROJECTED	
Service	**2011**	**2012**	**2013**	**Year 1**	**Year 2**
Diagnostic Cardiac Cath	376	322	218	393	494
Therapeutic Cardiac Cath	0	0	0	131	165
Total Adult Cardiac Cath Lab Cases	**376**	**322**	**218**	**524**	**659**
DRMC Cardiac Cath Labs	**1**	**1**	**1**	**1**	**1**
Volume of Weighted Cases Available (2,000 per lab)	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**
DRMC Weighted Cases	**376**	**322**	**218**	**655**	**824**
Lab Utilization	**18.8%**	**16.1%**	**10.9%**	**32.8%**	**41.2%**

16. **Section C, (Economic Feasibility) Item 1. Project Costs Chart**

The moveable equipment cost of $100,000 is noted. However, please list all equipment over $50,000.

The equipment projected to cost over $50,000 that is required to advance from diagnostic to therapeutic cardiac catheterization capabilities at DRMC would include an Intravascular Ultrasound System ("IVUS") and a Fractional Flow Reserve ("FFR") System. This equipment is recommended as part of the ACC/AHA/SCA&I guidelines, and are tools that aid in determining the clinical necessity of therapeutic cardiac catheterization. The cost of IVUS and an FFR System were priced as a combination unit, and the estimated cost is $100,000. A revised Project Cost Chart listing the equipment is attached following this response.

17. **Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)**

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

A revised Historical Data Chart and a Revised Projected Data Chart are attached following this response.

Please clarify if the projected data chart represents patients for the proposed therapeutic cardiac catheterization service, or the total patients for both diagnostic and therapeutic services.

The Projected Data Chart represents patients for the proposed therapeutic cardiac catheterization service, as well as just the incremental diagnostic cardiac catheterization volume that is projected as a result of initiating a therapeutic cardiac catheterization program at DRMC.

Please clarify why the Projected Data Chart reflects 333 patients in Year One and 467 patients in Year Two; while table 22 on page 40 of the application reflects 524 in Year One, and 658 in Year Two.

The Projected Data Chart is inclusive of the incremental patient volumes that are projected to result from an expansion in capabilities at DRMC to include therapeutic cardiac catheterization. Whereas, Table 22 on page 40 of the application is intended to denote the historical and projected utilization of the existing cardiac catheterization lab at DRMC. For an understanding of lab utilization, it is important to include the total volumes (existing plus new) of patients that would be cared for in the lab space. Therefore, the additional volumes included in Table 22 are inclusive of existing diagnostic cardiac catheterization, and projected new diagnostic and therapeutic patient volumes.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

HISTORICAL DATA CHART

Give information for the last three (3) years for which complete data are available for the facility or agency.

		Year: 2011	Year: 2012	Year: 2013
A.	Utilization/Occupancy Data	13,109	12,615	11,033
B.	Revenue from Services to Patients			
	1. Inpatient Services	$177,313,194	$161,453,832	$152,247,675
	2. Outpatient Services	$221,867,035	$243,735,249	$242,478,289
	3. Emergency Services	$39,556,905	$48,242,459	$53,582,570
	4. Other Operating Revenue	$522,408	$398,483	$351,637
	Specify: See Attachment			
	Gross Operating Revenue	$439,259,542	$453,830,023	$448,660,171
C.	Deductions from Operating Revenue			
	1. Contract Deductions	$361,201,645	$377,656,922	$377,527,536
	2. Provision for Charity Care	$2,143,445	$2,658,744	$1,578,834
	3. Provision for Bad Debt	$11,504,494	$12,376,445	$10,912,316
	Total Deductions	$374,849,584	$392,692,111	$390,018,686
NET OPERATING REVENUE		$64,409,958	$61,137,912	$58,641,485
D.	Operating Expenses			
	1. Salaries and Wages	$26,387,727	$24,305,121	$22,934,196
	2. Physicians' Salaries and Wages	$0	$0	$0
	3. Supplies	$7,436,910	$6,977,615	$6,340,693
	4. Taxes	$5,017,623	$5,496,546	$5,425,912
	5. Depreciation	$4,787,333	$5,338,108	$3,573,482
	6. Rent	$1,395,588	$1,460,407	$1,411,496
	7. Interest, other than Capital	$0	$0	$0
	8. Management Fees:			
	a. Fees to Affiliates	$2,185,199.00	$2,582,185.00	$2,278,576.00
	b. Fees to Non-Alffiliates	$0.00	$0.00	$0.00
	9. Other Expenses	$8,949,797.00	$10,301,713.00	$8,688,545.00
	Specify: See Attached.			
	Total Operating Expenses	$53,974,978.00	$53,879,510.00	$48,374,324.00
E.	Other Revenue (Expenses)--Net	$0.00	$0.00	$0.00
	Specify:			
NET OPERATING INCOME (LOSS)		$10,434,980.00	$7,258,402.00	$10,267,161.00
F.	Capital Expenditures			
	1. Retirement of Principal			
	2. Interest	$3,357,859.00	$3,681,870.00	$4,148,940.00
	Total Capital Expenditures	$3,357,859.00	$3,681,870.00	$4,148,940.00
NET OPERATING INCOME (LOSS)		$10,434,980.00	$7,258,402.00	$10,267,161.00
LESS CAPITAL EXPENDITURES		$3,357,859.00	$3,681,870.00	$4,148,940.00
NOI LESS CAPITAL EXPENDITURES		$7,077,121.00	$3,576,532.00	$6,118,221.00

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

HISTORICAL DATA CHART ATTACHMENT

Other Operating Revenue (Line B, 4):

- Cafeteria Revenue
- Vending Machine Revenue
- Medical Records copying fees
- Senior Circle Memberships
- Healthy Woman Memberships
- Rental Revenue
- Gain or Loss on Disposal of Fixed Assets
- Grant Income
- Other Misc. Revenue

OTHER EXPENSE CATEGORIES (Line D, 9)	**Year: 2011**	**Year: 2012**	**Year: 2013**
1. Medical Specialists Fees	$1,914,784	$2,018,643	$2,130,953
2. Purchased Services	$4,198,638	$4,631,095	$5,205,456
3. Physician Recruiting	$16,696	$52,164	$59,546
4. Repairs	$1,161,687	$1,448,925	$1,369,971
5. Marketing	$187,027	$125,609	$110,927
6. Utilities	$1,273,261	$1,238,750	$1,101,133
7. Other Misc. Operating Expense	$847,245	$786,534	$728,434
8. HITECH Incentives	-$649,541	-$7	-$2,017,875
Total Other Expenses	**$8,949,797**	**$10,301,713**	**$8,688,545**

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

PROJECTED DATA CHART

Give information for the two (2) years following completion of this proposal. The fiscal year begins in January.

		Year 1	Year 2
A.	Utilization/Occupancy Data (Patients)	333	467
B.	Revenue from Services to Patients		
	1. Inpatient Services	$ 17,021,709.33	$ 22,494,360.60
	2. Outpatient Services	$ 3,080,886.35	$ 4,459,727.84
	3. Emergency Services	$ -	$ -
	4. Other Operating Revenue (Specify) _____	$ -	$ -
	Gross Operating Revenue	**$ 20,102,595.68**	**$ 26,954,088.44**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	$ 16,942,793.50	$ 22,717,342.67
	2. Provisions for Charity Care	$ 70,415.51	$ 94,414.97
	3. Provisions for Bad Debt	$ 478,856.26	$ 642,063.06
	Total Deductions	**$ 17,492,065.28**	**$ 23,453,820.69**
NET OPERATING REVENUE		$ 2,610,530.40	$ 3,500,267.75
D.	Operating Expenses		
	1. Salaries and Wages	$ 130,352.98	$ 132,666.13
	2. Physicians' Salaries and Wages	$ 438,000.00	$ 438,000.00
	3. Supplies	$ 607,755.44	$ 849,295.20
	4. Taxes	$ -	$ -
	5. Depreciation	$ 40,000.00	$ 40,000.00
	6. Rent	$ -	$ -
	7. Interest, other than Capital	$ -	$ -
	8. Management Fees:		
	a. Fees to Affiliates	$ -	$ -
	b. Fees to Non-Affiliates	$ -	$ -
	9. Other Expenses	$ 97,198.34	$ 125,883.63
	Specify: See Attached		
	Total Operating Expenses	$ 1,313,306.75	$ 1,585,844.96
E.	Other Revenue (Expenses)--Net	$ (172,000.00)	$ (15,000.00)
	Specify: Marketing, Legal, Implementation		
NET OPERATING INCOME (LOSS)		$ 1,125,223.65	$ 1,899,422.79
F.	Capital Expenditures		
	1. Retirement of Principal	$ -	$ -
	2. Interest	$ -	$ -
	Total Capital Expenditures	$ -	$ -
NET OPERATING INCOME (LOSS)		$ 1,125,223.65	$ 1,899,422.79
LESS CAPITAL EXPENDITURES		$ -	$ -
NOI LESS CAPITAL EXPENDITURES		$ 1,125,223.65	$ 1,899,422.79

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

PROJECTED DATA CHART-OTHER EXPENSES

Explanation Line D, 8,a: It is not practically possible to allocate a portion of the Affiliate Mangement Fees for the entire hosptial to one secific service line.

OTHER EXPENSE CATEGORIES	Year 1	Year 2
1. Maintenance Contracts	$0.00	$20,000.00
2. ACC-NCDR Database Participation Fees	$5,625.00	$5,625.00
3. Indirect Expenses	$73,810.84	$98,196.13
4. Contingency Expense	$17,762.50	$2,062.50
Total Other Expenses	**$97,198.34**	**$125,883.63**

- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**
- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

RESPONSE: The costs for the project are set forth on the Project Cost Chart. The costs for this project are considered reasonable and relatively low due to DRMC already having a cardiac catheterization lab in place with diagnostic capabilities. DRMC will purchase the requisite equipment to advance its capabilities to offer PCI services.

Project Costs Chart	
A. Construction and Equipment acquired by purchase	Cost
1. Architectural and Engineering Fees	$0.00
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$147,000.00
3. Acquisition of Site	$0.00
4. Preparation of Site	$0.00
5. Construction Costs	$0.00
6. Contingency Fund	$17,763.00
7. Fixed Equipment (not included in construction costs)	$100,000.00
8. Moveable Equipment (Combined IVUS & FFR System)	$100,000.00
9. Other (Specify) _____	$0.00
B. Acquisition by gift, donation, or lease	
1. Facility (inclusive of building and land)	$0.00
2. Building only	$0.00
3. Land only	$0.00
4. Equipment (Specify)	$0.00
5. Other (Specify) _____	$0.00
C. Financing Costs and Fees	
1. Interim Financing	$0.00
2. Underwriting Costs	$0.00
3. Reserve for One Year's Debt Service	$0.00
4. Other (Specify)	$0.00
D. Estimated Project Cost (A + B + C)	$364,763.00
E. CON Filing Fee	$3,000.00
F. Total Estimated Project Cost (D + E)	$367,763.00
TOTAL	367,763.00

2. Identify the funding sources for this project.

18. **Section C. (Economic Feasibility) Item. 6. A Charges**

On page 47 the applicant states the anticipated revenue from the proposed project will total $2,610,350 in Year One and $3,500,268 in Year Two. Please revise the response to specify "Net Operating Revenue" will total $2,610,350 in Year One and $3,500,268 in Year Two and submit a replacement page.

The requested revision is reflected on replacement page 47, attached following this response.

The applicant states the cost of emergency transport would significantly decrease with the lack of need to transport patients outside the area for care. If possible, what would be the estimated transportation cost savings to the health care system if this proposed service is approved?

The costs associated with emergency transport directly relate to a few factors, with one being the distance that the vehicle or air transport would need to travel. With an expansion of capabilities at DRMC to include therapeutic cardiac catheterization, DRMC would be in a position to care for more complex patients, such as those experiencing a heart attack. Rather than have to transfer these patients to a provider located over 47 miles away into another county, the patient could receive care at DRMC. This elimination of a need for emergent transfer undoubtedly will reduce the cost to the health care system in west Tennessee. The total impact on the cost of the healthcare system may be difficult to determine, as the analysis would be multi-factorial and include a number of assumptions. With ground transfer costs exceeding $1,600 and air transfer costs exceeding $30,500 it is clear that the impact, however, of the initiating PCI services at DRMC will be significant (see table below). It can reasonably be assumed that the cost of transfer via either modality will increase as the distance to the destination hospital from DRMC increases.

Destination Hospital	Address	Ground Miles from DRMC	Ground Transfer Cost	Approx. Nautical Miles from DRMC	Air Transfer Cost
Regional Hospital of Jackson	367 Hospital Blvd Jackson, TN 38305	47.8 miles	$1,657	38.8 miles	$30,513
Jackson-Madison County General Hospital	620 Skyline Drive Jackson, TN 38301	48.4 miles	$1,666	41.9 miles	$31,775

C9605	N/A	$34,617.38
C9606	N/A	$34,617.38
C9607	N/A	$34,617.38
C9608	N/A	$34,617.38

The charges included in Table 23 above are reflective of the anticipated charges for PCI procedures, and are not inclusive of all charges involved in the patients' care. The anticipated net operating revenue from the proposed project, including projected PCI and incremental diagnostic catheterization volumes with this expansion of services, will total $2,610,530 in Year 1 and $3,500,268 in Year 2. There will be no anticipated impact on existing patient charges at DRMC. Although there will be no impact on charges, the cost to patients should decrease if DRMC were to offer PCI services, since they would be able to receive a diagnostic catheterization and PCI at one location at one time, minimizing the times the patient would need to undergo a cath procedure. Additionally, the cost of emergency transport would significantly decrease with the lack of need to transport as many patients outside of the area for care. It is important to note that the percentage of patients needing an urgent transfer to surgery during a PCI procedure is less than 0.3%.[27]

A. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: There are no providers in DRMC's service area that offer PCI services today. Therefore, comparisons cannot be made between DRMC's proposed charges and that of other providers in the service area. However, being that DRMC is part of a health system, the applicant worked with another system hospital, the Regional Hospital of Jackson, to develop proposed charges for this service. At this time, DRMC's proposed charges for PCI services are equal to those at the Regional Hospital of Jackson. It is important to note, however, that charge data for comparative facilities is not publically available at the CPT-code level in Tennessee.

The proposed charges for these procedures are just one aspect of the cost involved in caring for patients with these conditions. Without a provider with PCI capabilities in the service area, patients are forced to leave the service area and travel significant distances to receive treatment. This travel may include traditional modes of transportation in non-urgent situations. However, for patients experiencing a heart attack, it is likely to involve air or ground transport via EMS providers. The cost related to this mode of transport can increase the cost of patient care exponentially and should be factored into the cost of care equation.

1. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: The applicant expects that this project will be cost-effective within the first two years of operation given that projected utilization rates are sufficient to generate profitability. With a limited investment required to expand DRMC's capabilities in its existing cardiac catheterization lab space, the applicant expects to achieve a positive ROI even within the first full year of operation.

[27] Data Source: 2011 ACC guidelines

19. Section C. (Economic Feasibility) Item. 9

Table 24 is noted. However, it is unclear how the estimated Year One revenue and % of total project revenue were calculated for State and Federal Revenue programs. Please clarify.

The payor mix for cardiovascular patients cared for at DRMC includes over 80% that are attributable to State and Federal revenue programs (Medicare and Medicaid/TennCare). Additionally, approximately 3% of the payor mix is attributable to a Medically Indigent (uninsured/self-pay) patient population. When projecting net operating revenue for this project, DRMC applied its actual experience in regards to reimbursement to account for the projected incremental diagnostic cardiac catheterization patient volumes. Without having performed therapeutic cardiac catheterization procedures at DRMC, the applicant applied the anticipated Medicare case rates for projected Medicare patient volumes and the historical percent of payment relative to Medicare case rates for the other projected patient volumes by payor. As expected, reimbursement for a specific procedure varies by payor. In the case of the Medicaid/TennCare patient population, DRMC typically receives lower reimbursement rates for procedures when compared with commercial payors and Medicare. Therefore, when applying the expected case rates by payor, the actual percent of project revenues for the Medicaid patient population is lower than the actual percent of the expected payor mix. In this case, the cardiovascular patient payor mix is expected to include 74% Medicare, 8% Medicaid/TennCare, and 3% Medically Indigent (uninsured/self-pay), while the percent of project revenues is 75% Medicare, 3% Medicaid/TennCare, and 3% Medically Indigent.

20. Section C. (Contribution to Orderly Development) Item 1

Attachment C, (III (1) Contractual Agreements is noted. However, AMISUB (SFH) Inc. d/b/a St. Francis Hospital is not included. Please include in the attachment and resubmit.

A revised Attachment C, III, (1) Contractual Agreements is attached following this response.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

Dyersburg Regional Medical Center Health Care Contracts

Ahmad Al-Hamda, MD	On Call Coverage
Apex Cardiology	On Call Coverage
Brook Adams, MD	On Call Coverage
Oakwood Community Living Center	Patient Transfer
Duckworth Pathology Group	Pathology
Duckworth Pathology Group	Pathology
Dyersburg Manor Nursing & Rehab Center	Under Arrangements Skilled Nursing Facility
EmCare Physician Services, Inc.	Surgery
Family Care, PC	Cardiology
G Bradford Wright MD	On Call Coverage
James Naifeh, MD	On Call Coverage
Keith Nord MD	On Call Coverage
The Bridge at Ridgely	Patient Transfer
Memphis Hearing Aid & Audiological	Audiology
Mid South Transplant Foundation, Inc.	Organ Procurement or Harvesting
Monroe Carrell Jr Childrens Hospital at Vanderbilt	Patient Transfer
Reelfoot Manor Nursing Home	Patient Transfer
Regional Hospital of Jackson	Patient Transfer
St. Francis Hospital	Patient Transfer
The Highlands of Dyersburg	Patient Transfer
Timothy D Sweo MD	On Call Coverage
Vanderbilt University Medical Center	Patient Transfer
Virtual Radiological Professionals Of Minnesota PA	Radiology-Imaging
William Matthew Tosh DO	On Call Coverage

21. Section C. (Contribution to Orderly Development) Item 3

Please confirm the applicant will add a .5 FTE cardiology radiology technician and 1.0 FTE registered nurse if this proposed project is approved.

That is correct. DRMC has a complement of personnel in place to manage the existing diagnostic cardiac catheterization lab. With approval of this application, DRMC will need to add additional personnel to ensure the hospital has an adequate number of nurses and radiology technicians to continue to provide services Monday – Friday from 7am to 4pm, but now also to care for an emergent patient population that can present to the hospital at any time. The additional 1.5 FTEs coupled with the existing cardiac catheterization lab staff is expected to meet the need to manage the daily operations of the lab and account for an on-call team for non-operating times. DRMC's financial projections for this project, included in the Projected Data Chart, include the additional salaries required for this on-call time.

22. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

A Publisher's Affidavit is attached following this response.

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

STATE GAZETTE

294 US Highway 51 Bypass N.
Dyersburg, TN 38024
731-285-4091
Fax: 731-285-9747

I, Jina Jeffries, business manager of the State Gazette, a newspaper published at Dyersburg, Tennessee, hereby certify that the annexed advertisement has been published 1 consecutive/ non-consecutive days/weeks in said paper on the following dates: 3/9/14 and that the fee of $ 169.06 has/has not been paid.

Jina Jeffries

This 12th day of March, 2014

Notary Public

Commission expires: February 14, 2018

STATE OF TENNESSEE NOTARY PUBLIC COUNTY OF DYER

SUPPLEMENTAL- # 1
March 25, 2014
10:35am

CLASSIFIEDS

DEADLINES for Display Ads
Tuesday Friday 4 pm
Wednesday Monday 4 pm
Thursday Tuesday 4 pm
Friday Wednesday 4 pm
Sunday Thursday 4 pm

PHONE: 285-4091 · FAX: 286-6183

We reserve the right to reject any advertisement. We are responsible only for the first insertion of an advertisement. Advertisers are advised to check their ad immediately after it appears in the paper and report at once any errors found.

Legals

LEGAL 03-2506

NOTIFICATION OF INTENT TO APPLY FOR A Certificate of Need

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that: Dyersburg Regional Medical Center owned and managed by Dyersburg Hospital Corporation intends to file an application for a Certificate of Need for the expansion of its cardiac catheterization services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures, and the initiation of such services. Dyersburg Regional Medical Center is located at 400 Tickle Street, Dyersburg, Dyer County, Tennessee. Dyersburg Regional Medical Center is licensed as a general hospital by the Tennessee Board for Licensing Healthcare Facilities. The 8-licensed bed complement of the hospital will not be affected by this proposal. No major medical equipment is involved in this proposal. The estimated project cost is $367,763.20.

The anticipated date of filing the application is March 14, 2014.

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites and Harbison, PLLC, 401 Commerce Street, Suite 800, Nashville, Tennessee, 37219 615-782-2228

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to T.C.A. § 68-11-1607(c)(3): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Legals

LEGAL 02-2493

The estate of George Moody is looking for his daughter, Diane. Contact a 731-234-4007

LEGAL 02-2496

SUBSTITUTE TRUSTEE'S NOTICE OF FORECLOSURE SALE

Default having been made in the terms, conditions, and payments provided in a certain Deed of Trust dated NOVEMBER 7, 2008, executed by DUSTIN D. JOHNSON, A SINGLE MAN, to RALPH HENSON, Trustee, of record in RECORD BOOK 587, PAGE 559, for the benefit of MORTGAGE ELECTRONIC REGISTRATION SYSTEMS, INC. AS NOMINEE FOR FIRST CITIZENS NATIONAL BANK, in the Register's Office for DYER County, Tennessee and to J. PHILLIP JONES, appointed as Substitute Trustee in an instrument of record in the Register's Office for DYER County, Tennessee, to secure the indebtedness described, WHEREAS, the said Deed of Trust was last assigned to TENNESSEE HOUSING DEVELOPMENT AGENCY, the entire indebtedness having been declared due and payable by TENNESSEE HOUSING DEVELOPMENT AGENCY BY AND THROUGH ITS SERVICER AND AUTHORIZED AGENT, U.S. BANK NATIONAL ASSOCIATION, as provided in said Deed of Trust, I, J. PHILLIP JONES, will by virtue of the power and authority vested in me as Substitute Trustee, on FRIDAY, MARCH 21, 2014 AT 12:00 P.M. (NOON), AT THE NORTH DOOR OF THE DYER COUNTY COURTHOUSE IN DYERSBURG, DYER COUNTY, TENNESSEE, sell to the highest bidder for cash, free from the equity of redemption, homestead, and dower, and all other exemptions which are expressly waived, and subject to any unpaid taxes, if any, the following described property in DYER County, Tennessee, to wit:

PROPERTY LOCATED IN THE COUNTY OF DYER, TENNESSEE, LYING AND BEING IN THE 2ND CIVIL DISTRICT OF DYER COUNTY, TENNESSEE AND BEING LOT NO. 2 OF THE TRAVIS BURNS SUBDIVISION AS SHOWN BY MINOR SUBDIVISION PLAT RECORDED IN RECORD BOOK 476, PAGE 634 IN THE REGISTER'S OFFICE FOR DYER COUNTY, TENNESSEE, REFERENCE TO WHICH IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID REAL ESTATE, CONTAINING .75 ACRES MORE OR LESS.

BEING THE SAME PROPERTY CONVEYED TO DUSTIN D. JOHNSON, HIS HEIRS AND ASSIGNS, BY WARRANTY DEED DATED NOVEMBER 7, 2008 OF RECORD IN RECORD BOOK 587, PAGE 557, IN THE REGISTER'S OFFICE OF DYER COUNTY, TENNESSEE.

THIS IS IMPROVED PROPERTY KNOWN AS 100 EDMOND SORRELL ROAD, DYERSBURG, TENNESSEE 38024

MAP 122 PARCEL 019.03

THE SALE OF THE SUBJECT PROPERTY IS WITHOUT WARRANTY OF ANY KIND, AND IS FURTHER SUBJECT TO THE RIGHT OF ANY TENANT(S) OR OTHER PARTIES OR ENTITIES IN POSSESSION OF THE PROPERTY.

THIS SALE IS SUBJECT TO ANY UNPAID TAXES, IF ANY, ANY PRIOR LIENS OR ENCUMBRANCES, LEASES, EASEMENTS AND ALL OTHER MATTERS WHICH TAKE PRIORITY OVER THE DEED OF TRUST UNDER WHICH THIS FORECLOSURE SALE IS CONDUCTED, INCLUDING BUT NOT LIMITED TO THE PRIORITY OF ANY FIXTURE FILING. IF THE U.S. DEPARTMENT OF THE TREASURY/ INTERNAL REVENUE SERVICE, THE STATE OF TENNESSEE DEPARTMENT OF REVENUE, OR THE STATE OF TENNESSEE DEPARTMENT OF LABOR AND WORK FORCE DEVELOPMENT ARE LISTED AS INTERESTED PARTIES IN THE ADVERTISEMENT, THEN THE NOTICE OF THIS FORECLOSURE IS BEING GIVEN TO THEM, AND THE SALE WILL BE SUBJECT TO THE APPLICABLE GOVERNMENTAL ENTITIES RIGHT TO REDEEM THE PROPERTY, ALL AS REQUIRED BY 26 U.S.C. 7425 AND T.C.A. 67-1-1433. THE NOTICE REQUIREMENTS OF T.C.A. 35-5-101 ET SEQ. HAVE BEEN MET.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE.

IN THE EVENT THE HIGHEST BIDDER DOES NOT HONOR THE HIGHEST BID WITHIN 24 HOURS, THE NEXT HIGHEST BIDDER AT THE NEXT HIGHEST BID WILL BE DEEMED THE SUCCESSFUL BIDDER.

OTHER INTERESTED PARTIES: REPUBLIC FINANCE

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

This day, February 19, 2014. This is improved property known as 100 EDMOND SORRELL ROAD, DYERSBURG, TENNESSEE, 38024.

J. PHILLIP JONES
SUBSTITUTE TRUSTEE
1800 HAYES STREET
NASHVILLE, TN 37203
(615) 254-4430
www.phillipjoneslaw.com
F14-0136
Published: Feb 23, Mar 2 and Mar 9, 2014

LEGAL 03-2501

PROBATE COURT
JASON HUDSON
PROBATE JUDGE
DYER COUNTY

NOTICE TO CREDITORS

Civil Action No. 14-PR-10

Estate of Johnny Ray Crocker

Notice is hereby given on February 24, 2014 letters testamentary (or of administration as the case may be) in respect of the estate of Johnny Ray Crocker February 24, 2014 were issued to the undersigned by the Probate Court of Dyer County, Tennessee. All persons, resident and nonresident, having claims, matured or unmatured, against the estate are required to file the same with the clerk of the above named court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:

(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or

(2) Twelve (12) months from the decedent's date of death.

This 24th day of February 2014.

Administrator or Executor
Ralph L. Lawson

Attorney for the Estate:
Ralph I. Lawson
PO Box 1257
306 Church Ave. N.
Dyersburg, TN 38025

Publication dates:
March 2, 2014
March 9, 2014

LEGAL 03-2504

PROBATE COURT
JASON HUDSON
PROBATE JUDGE
DYER COUNTY

NOTICE TO CREDITORS

Civil Action No. 14-PR-17

Estate of James E. Lockhart

Notice is hereby given on February 27, 2014 letters testamentary (or of administration as the case may be) in respect of the estate of James E. Lockhart February 20, 2014 were issued to the undersigned by the Probate Court of Dyer County, Tennessee. All persons, resident and nonresident, having claims, matured or unmatured, against the estate are required to file the same with the clerk of the above named court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:

(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or

(2) Twelve (12) months from the decedent's date of death.

This 27th day of February 2014.

Administrator or Executor:
Suzanne Hotaling Fuller

Attorney for the Estate:
J. Michael Gauldin
113 S. Mill Ave
PO Box 220
Dyersburg, TN 38025

Publication dates:
March 9, 2014
March 16, 2014

LEGAL 03-2505

PROBATE COURT
JASON HUDSON
PROBATE JUDGE
DYER COUNTY

NOTICE TO CREDITORS

Civil Action No. 14-PR-5

Estate of R.C. Lineberry, Jr.

Notice is hereby given on November 22, 2013 letters testamentary (or of administration as the case may be) in respect of the estate of R.C. Lineberry, Jr. November 25, 2013 were issued to the undersigned by the Probate Court of Dyer County, Tennessee. All persons, resident and nonresident, having claims, matured or unmatured, against the estate are required to file the same with the clerk of the above named court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:

(1) (A) Four (4) months from the date of the first publication (or posting, as the case may be) of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication (or posting); or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication (or posting) as described in (1) (A); or

(2) Twelve (12) months from the decedent's date of death.

This 27th day of February 2014

Administrator or Executor:
First Citizens National Bank

Attorney for the Estate
John Palmer
116 Court St. W.,
PO Box 746
Dyersburg, TN 38025

Publication dates:
March 9, 2014
March 16, 2014

Yard Sales

Moving Sale - dining room set w/ 6 chairs, china cabinet, table w/ 3 chairs and cushion, ... $500. ... sewing machine $50. 2 wing back chairs $40 each. Call 285-... leave message

Sales

New Sales Opportunity
We're growing to accommodate demand for our supplemental health care products. $75K+ income potential, overnight travel typical 4 days/week. (855) 888-4110 ...

Super Savers

FOR SALE: Baby car seat $10, ... $45, Baby Walker $10, bag of infant clothes/blankets $10 ... 285-8861

FOR SALE: Panasonic DVD Player $75, ... $30, Craftsman 6 gal. air compressor $55 731-425-2316

FOR SALE: ... $50 731-259-3742

FS: Gazelle exercise walker ... $75, ... Call 445-5621

FS: ... computer desk $75, ... TV $25, ... $175, ... TV $75 731-796-0995

FS: oil heater $30 ...

FS: Refrigerator ... $50, ... $100, ... mattress $180, ... $75, ... Call ...

... washer & dryer $225. 731-442-0675

FS: youth bed with mattress and 4 drawer chest $145 285-8850

Local Author Carolese Marie Harris is selling a book she wrote, "Oh Look What The Lord Has Done"... stories about her and also other local people. $15/ea 637-3208

Help Wanted

... NO phone calls!

Drivers Needed

DRIVERS: NO EXPERIENCE? NO PROBLEM
14 Day Local Training in Jackson, TN to earn great pay, benefits, job security. Placement assistance & student tuition loans available. Call 1-800-423-8820 or go to www.drive-train.org for training opportunity with DRIVE-TRAIN 119 E.L. Morgan Drive

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DYER

NAME OF FACILITY: Dyersburg Regional Medical Center

I, Ben Youree, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

BY
Name

CEO
Title

Sworn to and subscribed before me this the 20th day of March, 2014, a Notary Public in and for Dyer County Tennessee.

Susan Stover
Notary Public

SUSAN STOVER
STATE OF TENNESSEE NOTARY PUBLIC
DYER COUNTY

My Commission Expires: 1-18-16.

SECOND SUPPLEMENTAL RESPONSES

CERTIFICATE OF NEED APPLICATION

FOR

DYERSBURG REGIONAL MEDICAL CENTER

Project No. CN1403-007

Expansion Of Existing Cardiac Catheterization Service to Include Interventional Cardiac Catheterization

Dyer County, Tennessee

March 27, 2014

Contact Person:

Jerry W. Taylor, Esq.
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, Tennessee 37219
615-782-2228

SUPPLEMENTAL

1. **Section C, Need, Item 4.A.**

   Your response to this item is noted. Please resubmit the following table using the year 2018 for the projected year (PY) rather than 2016 as previously submitted in the first supplemental.

   A revised table reflecting 2018 as the PY is attached following this response.

SUPPLEMENTAL

Variable	Crockett	Dyer	Gibson	Lake	Lauderdale	Obion	Service Area (Counties based in [illegible])	TN
Current Year (2014), Age 65+*	2,550	6,273	8,788	1,134	3,834	5,922	28,501	981,984
Projected Year (2018), Age 65+*	2,644	6,801	9,211	1,218	4,194	6,235	30,303	1,102,413
Age 65+, % Change	3.7%	8.4%	4.8%	7.4%	9.4%	5.3%	6.3%	12.3%
Age 65+, % Total (PY)	18.1%	17.8%	17.8%	12.7%	15.4%	19.9%	17.5%	16.4%
CY, Total Population*	14,596	38,218	51,102	9,732	27,341	31,453	172,442	6,588,698
PY, Total Population*	14,620	38,301	51,695	9,605	27,188	31,297	172,706	6,710,579
Total Pop. % Change	0.2%	0.2%	1.2%	-1.3%	-0.6%	-0.5%	0.2%	1.8%
TennCare Enrollees**	3,449	9,161	11,221	1,941	6,976	6,514	39,263	1,194,860
TennCare Enrollees as a % of Total Population(CY)	23.6%	24.0%	22.0%	19.9%	25.5%	20.7%	22.8%	18.1%
Median Age**	39.6	39.3	39.9	38.3	36.4	41.1	Not Avail.	38
Median Household Income***	$37,601	$38,167	$36,981	$26,212	$32,987	$40,516	Not Avail.	$44,140
Population % Below Poverty Level*****	19.2%	19.2%	18.6%	30.3%	26.1%	17.1%	Not Avail.	17.3%

2. **Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)**

   The revised Historical and Projected Data Charts with management fees are noted. Please recalculate the operating expense section for the years 2011, 2012, and 2013 of the Historical Data Chart and resubmit.

   A revised Historical Data Chart with recalculated operating expense entries is attached following this response.

   Please clarify why the Projected Data Chart for the proposed project does not include an allocation for management fees. If needed, please submit a revised Projected Data Chart with management fees included.

   The management fees cover all support services provided to each member hospital by CHS on a hospital-wide basis, and are not allocated by department or service line. Therefore, there is no practical way to allocate a portion of the fees to the cardiac catheterization services.

HISTORICAL DATA CHART

Give information for the last three (3) years for which complete data are available for the facility or agency.

		Year: 2011	Year: 2012	Year: 2013
A.	Utilization/Occupancy Data	13,109	12,615	11,033
B.	Revenue from Services to Patients			
	1. Inpatient Services	$177,313,194	$161,453,832	$152,247,675
	2. Outpatient Services	$221,867,035	$243,735,249	$242,478,289
	3. Emergency Services	$39,556,905	$48,242,459	$53,582,570
	4. Other Operating Revenue	$522,408	$398,483	$351,637
	Specify: See Attachment			
	Gross Operating Revenue	$439,259,542	$453,830,023	$448,660,171
C.	Deductions from Operating Revenue			
	1. Contract Deductions	$361,201,645	$377,656,922	$377,527,536
	2. Provision for Charity Care	$2,143,445	$2,658,744	$1,578,834
	3. Provision for Bad Debt	$11,504,494	$12,376,445	$10,912,316
	Total Deductions	$374,849,584	$392,692,111	$390,018,686
NET OPERATING REVENUE		$64,409,958	$61,137,912	$58,641,485
D.	Operating Expenses			
	1. Salaries and Wages	$26,387,727	$24,305,121	$22,934,196
	2. Physicians' Salaries and Wages	$0	$0	$0
	3. Supplies	$7,436,910	$6,977,615	$6,340,693
	4. Taxes	$5,017,623	$5,496,546	$5,425,912
	5. Depreciation	$4,787,333	$5,338,108	$3,573,482
	6. Rent	$1,395,588	$1,460,407	$1,411,496
	7. Interest, other than Capital	$0	$0	$0
	8. Management Fees:			
	a. Fees to Affiliates	$2,185,199.00	$2,582,185.00	$2,278,576.00
	b. Fees to Non-Alffiliates	$0.00	$0.00	$0.00
	9. Other Expenses	$8,949,797.00	$10,301,713.00	$8,688,545.00
	Specify: See Attached.			
	Total Operating Expenses	$56,160,177.00	$56,461,695.00	$50,652,900.00
E.	Other Revenue (Expenses)--Net	$0.00	$0.00	$0.00
	Specify:			
NET OPERATING INCOME (LOSS)		$8,249,781.00	$4,676,217.00	$7,988,585.00
F.	Capital Expenditures			
	1. Retirement of Principal			
	2. Interest	$3,357,859.00	$3,681,870.00	$4,148,940.00
	Total Capital Expenditures	$3,357,859.00	$3,681,870.00	$4,148,940.00
NET OPERATING INCOME (LOSS)		$8,249,781.00	$4,676,217.00	$7,988,585.00
LESS CAPITAL EXPENDITURES		$3,357,859.00	$3,681,870.00	$4,148,940.00
NOI LESS CAPITAL EXPENDITURES		$4,891,922.00	$994,347.00	$3,839,645.00

HISTORICAL DATA CHART ATTACHMENT

Other Operating Revenue (Line B, 4):

- Cafeteria Revenue
- Vending Machine Revenue
- Medical Records copying fees
- Senior Circle Memberships
- Healthy Woman Memberships
- Rental Revenue
- Gain or Loss on Disposal of Fixed Assets
- Grant Income
- Other Misc. Revenue

OTHER EXPENSE CATEGORIES (Line D, 9)	**Year: 2011**	**Year: 2012**	**Year: 2013**
1. Medical Specialists Fees	$1,914,784	$2,018,643	$2,130,953
2. Purchased Services	$4,198,638	$4,631,095	$5,205,456
3. Physician Recruiting	$16,696	$52,164	$59,546
4. Repairs	$1,161,687	$1,448,925	$1,369,971
5. Marketing	$187,027	$125,609	$110,927
6. Utilities	$1,273,261	$1,238,750	$1,101,133
7. Other Misc. Operating Expense	$847,245	$786,534	$728,434
8. HITECH Incentives	-$649,541	-$7	-$2,017,875
Total Other Expenses	**$8,949,797**	**$10,301,713**	**$8,688,545**

SUPPLEMENTAL

3. **Section C. (Economic Feasibility) Item. 9**

The response of how the estimated Year One revenue and % of total project revenue were calculated for State and Federal Revenue programs is noted. However, it remains unclear what amount from the projected data chart the applicant used to determine the percentage of total project revenue for Medicaid/TennCare and Medicare in Year One. HSDA staff calculates the percentage of gross charges in Year One as follows:

- **Medicaid/Tenncare: $603,078 or 3% gross operating revenue**
- **Medicare: $15,075,947 or 75% of gross operating revenue**
- **Indigent: $603,078 or 3% of gross operating revenue**

Please verify.

The applicant verifies the above amounts are correct based on projected patient mix as a percentage of projected gross operating revenue, with the exception that our calculation shows the projected Medicare revenue as $15,076,947, or 75% of gross operating revenue.

4. **Proof of Publication**

The publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent and a copy of the publication is noted. However, please provide an enlarged copy of the publication with a larger legible font.

An enlarged copy of the publication is attached following this response.

CLASSIFI

PHONE: 285-4091 · FAX: 286-6183

Legals

LEGAL 03-2506

NOTIFICATION OF INTENT TO APPLY
FOR A *Certificate of Need*

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Dyersburg Regional Medical Center owned and managed by Dyersburg Hospital Corporation intends to file an application for a Certificate of Need for the expansion of its cardiac catheterization services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures, and the initiation of such services. Dyersburg Regional Medical Center is located at 400 Tickle Street, Dyersburg, Dyer County, Tennessee. Dyersburg Regional Medical Center is licensed as a general hospital by the Tennessee Board for Licensing Healthcare Facilities. The licensed bed complement of the hospital will not be affected by this proposal. No major medical equipment is involved in this proposal. The estimated project cost is $367,753.00.

The anticipated date of filing the application is March 14, 2014.

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites and Harbison, PLLC, 401 Commerce Street, Suite 800, Nashville, Tennessee, 37219, 615-782-2228.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to T.C.A. § 68-11-1607(c)(1), (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

SUPPLEMENTAL

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Dyersburg Regional Medical Center

I, Jerry W. Taylor, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Name

Attorney

Title

Sworn to and subscribed before me this the 27th day of March, 2014, a Notary Public in and for Dyer County Tennessee.

Notary Public

NANCY JOHNSON STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.

My Commission Expires: 3-7-2017.

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 18, 2014

Jerry Taylor
Attorney
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, TN 37219

RE: Certificate of Need Application-CN1403-007
Initiation of Interventional (therapeutic) Cardiac Catheterization Procedures

Dear Mr. Taylor:

This will acknowledge our March 14, 2014 receipt of your application for a Certificate of Need for the expansion of Diagnostic Cardiac Catheterization Services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures at Dyersburg Regional Medical Center (DRMC), Dyersburg (Dyer County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Tuesday, March 25, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A, Item 3**

   Please provide the names of the owners (5% interest or greater) of Community Health System and indicate their percentage of ownership.

   Please list hospitals own by Community Health Systems in Tennessee and Missouri.

   Please discuss the proposed organizational and business relationships among these entities in such a manner that their affiliation with project can be understood. An organization chart will be helpful.

2. **Section A, Item 9 Bed Complement Data**

   The bed complement data chart is noted. Please complete the "Total Beds at Completion" column.

3. **Section A, Applicant Profile, Item 13**

The applicant's contractual relationships with Bluecare, United Community Healthcare Plan and TennCare Select are noted. However, new TennCare contracts will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United Healthcare. Please indicate if the applicant intends to contract with AmeriGroup. If so, what stage of contract discussions is the applicant involved with AmeriGroup?

Please clarify if the applicant has a Medicaid contract with Missouri.

What type of contracts does DRMC have with Missouri insurance organizations?

4. **Section B, Project Description, Item 1**

Your response is noted. Please provide an executive summary not to exceed two (2) pages. Please list the following areas as headers and address each area under the appropriate header: proposed services and equipment; ownership structure; service area; need; existing resources; project cost; funding; financial feasibility; and staffing.

What are the hours of DRMC's cardiac catheterization lab? What plans does the applicant have for therapeutic catheterization procedures during non-operating times?

5. **Section B, Project Description, Item II A.**

The applicant states the inability to provide therapeutic cardiac catheterization (PCI) services will have the potential to erode DRMC's diagnostic catheterization volumes thus impacting the program's long-term viability. With this in mind, how has the volumes and viability of the program been impacted since the implementation of CN-0509-83A for the Initiation of Diagnostic Cardiac Catheterization without therapeutic catheterization?

6. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 3**

The transfer agreements to three (3) hospitals are noted. Please complete the following table:

Hospital	Distance From DRMC	Emergency Travel Time from DRMC to facility by air	2013 # Transfers By air	Emergency Travel Time from DRMC to Facility by ground	2013 # Transfers by ground	2013 # Transfers for open heart surgery	2013 # Transfers for therapeutic catheterization
Vanderbilt Medical Center							
Regional Hospital of Jackson							
St. Francis Hospital							
*Methodist							

Healthcare-Memphis							
Other (Please list individually)							
Total							

**listed in CN0509-83A as hospital for patients requiring therapeutic services or open heart surgery.*

It appears Vanderbilt Medical Center is not within the 60 minute compliance for patient transfer. Please clarify the reason the applicant does not have a transfer agreement with a closer Shelby County tertiary hospital with similar services.

Please discuss the services available at Vanderbilt Medical Center, the Regional Hospital of Jackson and St. Francis Hospital for patients who are transferred for higher levels of heart care from DRMC.

It appears the three provided hospital transfer agreements were signed from March 2013 to May 2013. Please list the prior hospital transfer agreements for DRMC from the implementation of CN0509-083A of May 4, 2010 to March 2013.

If the hospitals with transfer agreements with DRMC prior to March 2013 are different from the existing hospitals, why did the DRMC seek other hospitals to transfer heart patients?

Please provide a letter of interest from a Madison and/or Shelby County hospital regarding a possible transfer agreement specific to open heart surgery.

7. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 7**

Please discuss DRMC's plan to maintain qualified cardiologist for the proposed services.

If a cardiologist unexpectedly leaves DRMC, what would DRMC do to ensure the continuity of the proposed service?

8. **Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 9**

Table 5 of distances to nearest PCI centers and cardiac services are noted. It appears the nearest facility with open heart surgery capabilities is Jackson-Madison County General Hospital in Jackson, TN. Please explain why there is not a transfer agreement with this facility when it is best to be under 60 minutes transfer time for heart patients.

Please request the Age Group-Specific Historical State Cardiac Catheterization Utilization Rate from the Tennessee Department of Health based upon information from the Hospital Discharge System. Please refer to page 11 of the State Health Plan Certificate of Need Standards and Criteria for Cardiac Catheterization Services that defines "Age Group-Specific Historical State Utilization Rate" for the purpose of defining need in the proposed service area.

Please note: As indicated in the State Health plan, the age group-specific historical state utilization rate will be calculated separately for diagnostic and therapeutic catheterization cases and will be a running average. The Department of Health shall

maintain the ongoing age group-specific historical state utilization rate to avoid breaches of patient confidentiality.

Please clarify how the applicant came to the conclusion that 25% of patients transferred from DRMC received a therapeutic catheterization procedure.

9. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 9

In table 10 there is a slight calculation error in Year Two "Total Adult Cardiac Cath Lab Cases". Please revise.

10. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 15

The applicant states a formal transfer agreement with an open heart tertiary center will be maintained. Please clarify the name of the open heart tertiary center the applicant is referring.

11. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 16

Please clarify if the existing two DRMC cardiologists meet the minimum physician requirements to initiate the proposed therapeutic cardiac catheterization program.

Please provide the following information for the two existing DRMC cardiologists: 1) estimated number of diagnostic cardiac procedures conducted for the past five (5) years, and 2) the estimated number of therapeutic cardiac procedures conducted for the past five (5) years.

Please provide the names and credentials (i.e., curriculum vitae's and Board Certificates) for the physicians on the hospital's medical staff who will be performing these procedures. Please note those physicians who are board certified invasive and/or interventional cardiologists.

12. Section C. 1. Need (Specific Criteria - Cardiac Catheterization) Item 18

The applicant states a cardiologist departed from DRMC in 2012. Please clarify if the cardiologist left because of the lack of therapeutic cardiac catheterization capabilities at DRMC.

13. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

Variable	*Crockett*	*Dyer*	*Gibson*	*Lake*	*Lauderdale*	*Obion*	*Service Area*	*TN*
Current Year (CY), Age 65+								
Projected Year (PY), Age 65+								
Age 65+, % Change								
Age 65+, % Total (PY)								
CY, Total Population								
PY, Total Population								
Total Pop. % Change								
TennCare Enrollees								
TennCare Enrollees as a % of Total Population								
Median Age								
Median Household Income								
Population % Below Poverty Level								

14. Section C, Need, Item 5

Table 17 on page 36 is noted. However, there appears to be calculation errors in the grand total of the chart. Please revise.

15. Section C, Need, Item 6

Table 21 on page 39 is noted. However, there appears to be slight calculation errors in the DRMC PCI volume for Year 1 and Year 2. If needed, please revise.

Table 22 is noted. However, there appears to be a slight calculation error in the number of projected total adult cardiac cath lab cases in Year 2. If needed, please revise.

16. Section C, (Economic Feasibility) Item 1. Project Costs Chart

The moveable equipment cost of $100,000 is noted. However, please list all equipment over $50,000.

17. Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees

should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Please clarify if the projected data chart represents patients for the proposed therapeutic cardiac catheterization service, or the total patients for both diagnostic and therapeutic services.

Please clarify why the Projected Data Chart reflects 333 patients in Year One and 467 patients in Year Two; while table 22 on page 40 of the application reflects 524 in Year One, and 658 in Year Two.

18. Section C. (Economic Feasibility) Item. 6. A Charges

On page 47 the applicant states the anticipated revenue from the proposed project will total $2,610,350 in Year One and $3,500,268 in Year Two. Please revise the response to specify "Net Operating Revenue" will total $2,610,350 in Year One and $3,500,268 in Year Two and submit a replacement page.

The applicant states the cost of emergency transport would significantly decrease with the lack of need to transport patients outside the area for care. If possible, what would be the estimated transportation cost savings to the health care system if this proposed service is approved?

19. Section C. (Economic Feasibility) Item. 9

Table 24 is noted. However, it is unclear how the estimated Year One revenue and % of total project revenue were calculated for State and Federal Revenue programs. Please clarify.

20. Section C. (Contribution to Orderly Development) Item 1

Attachment C, (III (1) Contractual Agreements is noted. However, AMISUB (SFH) Inc. d/b/a St. Francis Hospital is not included. Please include in the attachment and resubmit.

21. Section C. (Contribution to Orderly Development) Item 3

Please confirm the applicant will add a .5 FTE cardiology radiology technician and 1.0 FTE registered nurse if this proposed project is approved.

22. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written**

notification is Friday, May 16, 2014. If this application is not deemed complete by this date, the application will be deemed void. Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ∋ 68-11-1607(d):

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Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enclosure

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year____	Year___	*Year*____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	$_____	$_____	$_____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE	$_____	$_____	$_____
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses – Specify on separate page 12	_____	_____	_____
Total Operating Expenses	$_____	$_____	$_____
E. Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	$_____	$_____	$_____
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$_____	$_____	$_____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	**$**_____	**$**_____
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	**$**_____	**$**_____
NET OPERATING REVENUE		**$**_____	**$**_____
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on separate page 12	_____	_____
	Total Operating Expenses	**$**_____	**$**_____
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		**$**_____	**$**_____
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	**$**_____	**$**_____

NET OPERATING INCOME (LOSS) $_____ $_____
LESS CAPITAL EXPENDITURES

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

March 26, 2014

Jerry Taylor
Attorney
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, TN 37219

RE: Certificate of Need Application-CN1403-007
Initiation of Interventional (therapeutic) Cardiac Catheterization Procedures

Dear Mr. Taylor:

This will acknowledge our March 25, 2014 receipt of your supplemental response for a Certificate of Need for the expansion of Diagnostic Cardiac Catheterization Services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures at Dyersburg Regional Medical Center (DRMC), Dyersburg (Dyer County), Tennessee.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday, March 28, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section C, Need, Item 4.A.**

   Your response to this item is noted. Please resubmit the following table using the year 2018 for the projected year (PY) rather than 2016 as previously submitted in the first supplemental.

Variable	*Crockett*	*Dyer*	*Gibson*	*Lake*	*Lauderdale*	*Obion*	*Service Area*	*TN*
Current Year (CY-2014), Age 65+								
Projected Year (PY-2018), Age 65+								
Age 65+, % Change								
Age 65+, % Total (2018)								
CY, Total Population								
PY (2018), Total Population								
Total Pop. % Change								
TennCare Enrollees								
TennCare Enrollees as a % of Total Population								
Median Age								
Median Household Income								
Population % Below Poverty Level								

2. **Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)**

   The revised Historical and Projected Data Charts with management fees are noted. Please recalculate the operating expense section for the years 2011, 2012, and 2013 of the Historical Data Chart and resubmit.

   Please clarify why the Projected Data Chart for the proposed project does not include an allocation for management fees. If needed, please submit a revised Projected Data Chart with management fees included.

3. **Section C. (Economic Feasibility) Item. 9**

   The response of how the estimated Year One revenue and % of total project revenue were calculated for State and Federal Revenue programs is noted. However, it remains unclear what amount from the projected data chart the applicant used to determine the percentage of total project revenue for Medicaid/TennCare and Medicare in Year One. HSDA staff calculates the percentage of gross charges in Year One as follows:

   - Medicaid/Tenncare: $603,078 or 3% gross operating revenue
   - Medicare: $15,075,947 or 75% of gross operating revenue
   - Indigent: $603,078 or 3% of gross operating revenue

   Please verify.

4. Proof of Publication

The publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent and a copy of the publication is noted. However, please provide an enlarged copy of the publication with a larger legible font.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday, May 16, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

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Sincerely,

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HSD Examiner

Enclosure